Acknowledgment of Receipt of Notice of Privacy Practices

of Penny E. Siegmann-Beiner, LCSW-R

I hereby acknowledge that I have received the Notice of Privacy Practices of the above practice.

_____ _____

Patient Signature Date

_____

Print Name

Office Use Only

Acknowledgment of Receipt of Notice of Privacy Practices was not obtained from patient (name) _____due to:

____ Patient refusal

____ Patient lack of understanding

____ Emergency

____Other: specify

Patient ____was ____was not offered, ____did _____did not accept a copy of written Notice of Privacy Practices:

Staff Name:_____ Staff Signature:_____

Date:_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES

The following is the Notice of Privacy Practices of Penny E. Siegmann-Beiner, LCSW-R. HIPAA is a federal law that requires us to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy policies with respect to your protected health information. We are required by law to abide by the terms of this Notice of Privacy Practices.

Your Protected Health Information

Your "protected health information" (PHI) broadly includes any health information, oral, written or recorded, that is created or received by us, other healthcare providers, and health insurance companies or plans, that contains data, such as your name, address, social security or patient identification number, and other information, that could be used to identify you as the individual patient who is associated with that health information.

Rules on How We May Use or Disclosure Your Protected Health Information

Generally, we may not "use" or "disclose" your PHI without your permission, and must use or disclose your PHI in accordance with the terms of your permission. "Use" refers generally to activities within our office. "Disclosure" refers generally to activities involving parties outside of our office. The following are the circumstances under which we are permitted or required to use or disclose your PHI. In all cases, we are required to limit such uses or disclosures to the minimal amount of PHI that is reasonably required.

Without Your Written Authorization, Treatment, Payment and Health Operations

Without your written authorization, we may use within our office, or disclose to those outside our office, your PHI in order to provide you with the treatment you require or request, to collect payment for our services, and to conduct other related health care operations as follows:

Treatment activities include: (a) use within our office by our professional staff for the provision, coordination, or management of your health care at our office; and (b) our contacting you to provide appointment reminders or information about treatment alternatives or other health-related services that may be of interest to you.

Payment activities include: (a) if you initially consent to treatment using the benefits of your contract with your health insurance plan, we will disclose to your health plans or plan administrators, or their appointed agents, PHI for such plans or administrators to determine coverage, for their medical necessity reviews, for their appropriateness of care reviews, for their utilization review activities, and for adjudication of health benefit claims; (b) disclosures for billing for which we may utilize the services of outside billing companies and claims processing companies with which we have Business Associate Agreements that protect the privacy of your PHI; and (c) disclosures to attorneys, courts, collection agencies and consumer reporting agencies, of information as necessary for the collection of our unpaid fees, provided that we notify you in writing prior to our making collection efforts that require disclosure of your PHI.

Health care operations include: (a) use within our office for training of our professional staff and for internal quality control and auditing functions (b) use within our office for general administrative activities such as filing, typing, etc.; and (c) disclosures to our attorney, accountant, bookkeeper and similar consultants to our healthcare operations, provided that we shall have entered into Business Associate Agreements with such consultants for the protection of your PHI.

PLEASE NOTE THAT UNLESS YOU REQUEST OTHERWISE, AND WE AGREE TO YOUR REQUEST, WE WILL USE OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION FOR TREATMENT ACTIVITIES, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS AS SPECIFIED ABOVE, WITHOUT WRITTEN AUTHORIZATION FROM YOU.

Without Your Written Authorization, Special Situations and As Required By Law

In limited circumstances, we may use or disclose your PHI without your written authorization and in accord with HIPAA or as required by law. *Examples include*: (a) disclosures regarding reports of child abuse or neglect, including reporting to social service or child protective services agencies; (b) disclosures to State authorities of imminent risk of

danger presented by patients to self or others for the purpose of restricting patient access to firearms; (c) health oversight activities including audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, or other lawful process; (e) to the extent necessary to protect you or others from a serious imminent risk of danger presented by you; (f) for worker's compensation claims, (g) as required by the Secretary of Health and Human Services to investigate or determine our compliance with federal regulations, including those regarding government programs providing public benefits, (h) for research projects where your PHI has been de-identified, that is no longer identifies you by name or any distinguishing marks, and cannot be associated with you, (i) to a public or private entity to assist in disaster relief efforts authorized by law, (j) to family members, friends and others involved in your care, but only if you are present and give oral permission

Minimum Necessary Rule: We will use or disclose your PHI without your authorization for the above purposes only to the extent necessary, and will release only the minimum necessary amount of PHI to accomplish the purpose.

All Other Situations, With Your Specific Written Authorization

Except as otherwise permitted or required as described above, we may not use or disclose your PHI without your written authorization. Written authorization is required, among other uses and disclosures, for (1) most uses and disclosures of Psychotherapy Notes, (2) uses and disclosures for marketing purposes, (3) uses and disclosures that involve the sale of PHI and (4) other uses and disclosures not described in this Notice. Further, we are required to use or disclose your PHI consistent with the terms of your authorization. You may revoke your authorization to use or disclose any PHI at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy. We will not sell your PHI or use your PHI for paid marketing or fundraising purposes without your written authorization; we do not plan to use your PHI in marketing or fundraising.

Special Handling of Psychotherapy Notes

"Psychotherapy Notes" are defined as records of communications during individual or family counseling which may be maintained in addition to and separate from medical or healthcare records. Psychotherapy Notes are only released with your specific written authorization except in limited instances, *including*: (a) if you sue us or place a complaint, we may use Psychotherapy Notes in our defense; (b) to the United States Department of Health and Human Services in an investigation of our compliance with HIPAA; (c) to health oversight agencies for a lawful purpose related to oversight of our practice; and (d) to the extent necessary to protect you or others from a serious imminent risk of danger presented by you. Health insurers may not condition treatment, payment, enrollment, or eligibility for benefits on obtaining authorization to review, or on reviewing, Psychotherapy Notes.

Your Rights With Respect to Your Protected Health Information

Under HIPAA, you have certain rights with respect to your PHI. The following is an overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your PHI. While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your protected healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law. If you have paid for our services in full yourself, out-of-pocket, then we must comply with your request to restrict those disclosures of your PHI that would otherwise be made for payment or healthcare operations, that are unnecessary because of your manner of payment. We require that all requests for restrictions be in writing and specify (1) the information to be restricted, (2) the type of restriction being requested, and (3) to whom the limits apply. You must also state a reason for the request. We will respond in writing to all requests within 30 days or receipt.

Right To Receive Confidential Communications By Alternative Means And At Alternative Locations

We must permit you to request and must accommodate reasonable requests by you to receive communications of PHI from us by alternative means or at alternative locations. We will ask you how you wish us to communicate with you. We must agree to your request if you inform us that certain of means of communicating with you will place you in danger.

Right To Inspect and Copy Your Protected Health Information, Including In Electronic Format

You have the right of access in order to inspect, and to obtain a copy of your PHI, including any PHI maintained in electronic format, *except for* (a) personal notes and observations of the treating provider, (b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, (c) health information maintained by us to the extent to which the provision of access to you is at our discretion, and we exercise our professional judgment to deny you access, and (d) health information maintained by us to the extent to which the provision of access to you would be prohibited by law.

We require written requests for copies of your PHI; they should be sent to our Privacy-Security Officer at the mailing address below. You may request your PHI in the format of your choice, and where feasible, we will comply. If you request a copy of your PHI, we will charge a fee for copying, or for electronic records, for labor and supplies. We reserve the right to deny you access to and copies of all or certain PHI as permitted or required by law. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the basis for denial, a statement of your rights, and a description of how you may file an appeal or complaint.

Right To Amend Your Protected Health Information

You have the right to request that we amend your PHI, for as long as your medical record is maintained by us. We have the right to deny your request for amendment. We require that you submit written requests and provide a reason to support the requested amendment.

If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us and/or the Secretary of the U.S. Department of Health and Human Services (DHHS). If we accept your request for amendment, we will make reasonable efforts to provide the amendment within a reasonable time to persons identified by you as having received PHI of yours prior to amendment and persons that we know have the PHI that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendments shall be sent to our Privacy-Security Officer at the mailing address below.

Right To Receive An Accounting Of Disclosures Of Your PHI And Electronic Health Records

You have the right to receive a written accounting of all disclosures of your PHI for which you have not provided an authorization that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of such disclosure for a period of time less than six (6) years from the date of the request. We require that you request an accounting in writing on a form that we will provide to you.

The accounting of disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, instead of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. *We are not required to provide accountings of disclosures for the following purposes*: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) to other healthcare providers involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/2003. We reserve the right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to our Privacy-Security Officer at the mailing address below.

If we maintain any PHI in electronic form, then you may also request and receive an accounting of any disclosures of your electronic health records made for purposes of treatment, payment and health operations during the prior three (3) year period. Upon request, one list will be provided for free every twelve (12) months.

Right To Notification If There Is A Breach of Your Protected Health Information If there is a breach in our protecting your PHI, we will follow HIPAA guidelines to evaluate the circumstances of the breach, document our investigation, retain copies of the evaluation, and where necessary, report breaches to DHHS. Where a report is required to DHHS, we will also give you notification of any breach.

Business Associate Rule

Business Associates are entities that in the course of our business with them will obtain access to your PHI. They may use, transmit, or view your PHI on our behalf. Business Associates are prohibited from re-disclosing your PHI without your written consent, or unless disclosure is required by law. We enter into confidentiality agreements with our Business

Associates called Business Associate Agreements, and they in turn enter into confidentiality agreements with their subcontractors, if any.

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. Please submit any complaint to us in writing by mail to our Privacy-Security Officer at the mailing address below. A complaint must name the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Notice of Privacy Practices. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint. To file a complaint with the Secretary of DHHS, write or call:

The US Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
877-696-6775

Amendments to this Notice of Privacy Practices

We reserve the right to revise or amend this Notice of Privacy Practices at any time. These revisions or amendments may be made effective for all PHI we maintain even if created or received prior to the effective date of the revision or amendment. Upon your written request, we will provide you with notice of any revisions or amendments to this Notice of Privacy Practices, or changes in the law affecting this Notice of Privacy Practices, by mail or electronically within 60 days of receipt or your request.

Ongoing Access to Notice of Privacy Practices

We will provide you with a copy of the most recent version of this Notice of Privacy Practices at any time upon your written request sent to our Privacy-Security Officer at the mailing address below. For any other requests or for further information regarding the privacy of your PHI, and for information regarding the filing of a complaint, please contact us at the address, telephone number, or e-mail address listed above.

To Contact Us

This is our contact information referred to above.
Our Privacy-Security Officer is: Bruce Hillowe, JD. Our mailing address is: 54 Chicago Ave., Massapequa NY 11758.
Our telephone number is: 516-528-6712.

INFORMED CONSENT TO INDIVIDUAL PSYCHOTHERAPY

This form documents that I,_____, give my consent to Penny Siegmann-Beiner, LCSW-R, Kenneth Beiner, LMSW (the "psychotherapist") and/or Rosie Carino, LMSW (the "psychotherapist"), to provide psychotherapeutic treatment to me. (Rosie Carino, LMSW is supervised by Penny Siegmann-Beiner, LCSW-R, Kenneth Beiner, LMSW is supervised by Joanna Suppa, LCSW-R, and all are employed by Penny Siegmann-Beiner, LCSW-R.)

While I expect benefits from this treatment, I fully understand that no particular outcome can be guaranteed. I understand that I am free to discontinue treatment at any time but that it would be best to discuss with the psychotherapist any plans to end therapy before doing so.

I have fully discussed with the psychotherapist what is involved in psychotherapy and I understand and agree to the policies about scheduling, fees and missed appointments. I understand that I am fully financially responsible for treatment, which, if I have health insurance, includes any portion of the psychotherapist's fees that are not reimbursed by my insurance. I understand that the frequency of my sessions will be ___1x/week_____, that I am fully responsible for payment of all deductibles and co-payments if I have health insurance, that the frequency of billing will be at least monthly and that payment will be due at the session that immediately follows my receipt of a bill, and that I will be personally responsible for payment in full for any canceled session if I do not give the psychotherapist at least 24 hours advance notice of the cancellation.

Our discussion about therapy has included the psychotherapist's evaluation and diagnostic formulation of my problems, the method of treatment, goals and length of treatment, and information about record-keeping. I have been informed about and understand the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment. I understand that therapy can sometimes cause upsetting feelings to emerge, that I may feel worse temporarily before feeling better, and that I may experience distress caused by changes I may decide to make in my life as a result of therapy.

I understand that the psychotherapist cannot provide emergency service. The psychotherapist has told me whom to call if an emergency arises and the psychotherapist is unavailable. In any case, I understand that in any emergency, I may call 911 or go the nearest hospital emergency room.

I have received a HIPAA Notice of Privacy Practices from the psychotherapist. I understand that information about psychotherapy is almost always kept confidential by the psychotherapist and not revealed to others unless I give my consent. There are a few exceptions as noted in the HIPAA Notice of Privacy Practices. Details about certain of those exceptions follow:

1. The psychotherapist is required by law to report suspected child abuse or neglect to the proper authorities. The psychotherapist is also mandated to report to the authorities patients who are at imminent risk of harming themselves or others for the purpose of those authorities checking to see whether such patients are owners of firearms, and if they are, or apply to be, then limiting and possibly removing their ability to possess them.

2. If I tell the psychotherapist that I intend to harm another person, the psychotherapist must try to protect that person, including by telling the police or the person or other health care providers. Similarly, if I threaten to harm myself, or my life or health is in any immediate danger, the psychotherapist will try to protect me, including by telling others such as my relatives or the police or other health care providers, who can assist in protecting or assisting me.

3. If I am involved in certain court proceedings the psychotherapist may be required by law to reveal information about my treatment. These situations include child custody disputes, cases where a therapy patient's psychological condition is an issue, lawsuits or formal complaints against the psychotherapist, civil commitment hearings, and court-related treatment.

4. If my health insurance or managed care plan will be reimbursing me or paying the psychotherapist directly, they will require that I waive confidentiality and that the psychotherapist give them information about my treatment.

5. The psychotherapist may consult with other psychotherapists about my treatment, but in doing so will not reveal my name or other information that would identify me unless specific consent to do so is obtained. Further, when the psychotherapist is away or unavailable, another psychotherapist might answer calls and so will need to have access to information about my treatment.

6. If my account with the psychotherapist becomes overdue and I do not pay the amount due or work out a payment plan, the psychotherapist will reveal a limited amount of information about my treatment in taking legal measures to be paid. This information will include my name, patient identification number, address, dates and type of treatment and the amount due.

In all of the situations described above I understand that the psychotherapist will try to discuss the situation with me, or notify me, before any confidential information is revealed, and will reveal only the least amount of information that is necessary.

If I am participating in a managed care plan, I have discussed with the psychotherapist the plan's limits, if any, on the number of therapy sessions. I have discussed with the psychotherapist my options for continuation of treatment when my managed care benefits end.

I understand that I have a right to ask the psychotherapist about the psychotherapist's training and qualifications and about where to file complaints about the psychotherapist's professional conduct.

By signing below, I am indicating that I have read and understood this form and that I give my consent to treatment.

Signature:_____ Date:_____
(of patient or person authorized to consent for patient)

Print Name:_____
(of patient or person authorized to consent for patient)

AUTHORIZATION FORM (HIPAA)

Authorization for Disclosure of Protected Health Information

Name of Patient:_____

1.I authorize the healthcare practitioner: *Penny Siegmann-Beiner, LCSW-R (54 Chicago Ave, Massapequa NY 11758)* (the 'Practitioner") and/or the administrative and clinical staff of the Practitioner to disclose my (or my child's or my ward's) protected health information, as specified below, to:

a) Insurer _____ b) PCP_____

c) Psychiatrist/Nurse Practitioner/PA_____

d) Other _____ e) Other_____

2. I am hereby authorizing the disclosure of the following protected health information:

Mental Health Treatment – including assessment, biopsychosocial history, diagnosis, dates of service, type of service, progress notes, medication, concomitant issues (including drug and alcohol treatment, treatment related to HIV), billing, etc.

3. This protected health information is being used or disclosed for the following purposes:

Coordination of Care, Billing

4. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practitioner at the address above. I understand that a revocation is not effective to the extent that the Practitioner has relied on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

5. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA or any other federal or state law, provided however, that Confidential HIV Related Information and Alcohol/Substance Abuse Treatment Information may not re-disclosed without my authorization unless permission to re-disclose such information is granted by federal or state law.

6. The Practitioner will not condition my treatment on whether I provide an authorization for disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____

Signature of Patient, or Parent of Minor Patient, or Personal Representative of Patient — Date

_____

Print Name of Patient, Parent of Minor Patient or Personal Representative of Patient (If a Personal Representative, also state relationship to patient.)

AGREEMENT REGARDING PSYCHOTHERAPIST'S FEES FOR LEGAL INVOLVEMENT

I/We,_____(the patient or parent of the patient), understand that if Penny Siegmann-Beiner, LCSW-R (the psychotherapist), and/or the clinical or administrative staff of the Psychotherapist, is required to, is requested to, or agrees to, be involved in a legal matter concerning me or my child(ren), then I will be responsible to compensate the psychotherapist for all time expended. I understand that any health insurance benefits I may have do not cover the time or services of psychotherapists spent on patients' legal involvements.

I agree that the psychotherapist's fees for case preparation, record review, telephone calls, correspondence, conferences, written reports, any testimony and consultations with lawyers, including the psychotherapist's lawyer, or other court personnel, will be calculated at the rate of $ **150.00** per hour.

Fees for all of the above activities will be payable in advance of any of those activities and will be based on the psychotherapist's estimate of the time that will be necessary for them. Any overpayment of fees will be refunded to me within 10 days of when the psychotherapist is notified that the legal matter has been finally settled or it otherwise becomes certain, as determined at the sole discretion of the psychotherapist, that it will not be necessary for the psychotherapist to spend additional time on legal involvement in the case. The psychotherapist may request, and I will pay, additional amounts if the original amount turns out to be an underestimate of the actual amount needed.

Fees for any testimony will be payable at least 2 weeks in advance of the date scheduled and will be based on the psychotherapist's estimate of the time for testimony and the time traveling to and from the place where the testimony will be given. The actual fee will be computed from the time the psychotherapist arrives at the place where testimony is to be given until the time the psychotherapist is dismissed, plus travel time to and from the place of testimony from the psychotherapist's office. Any adjustments from the estimate will be made after all testimony of the psychotherapist has been completed.

I understand that if, after the psychotherapist's testimony is scheduled, it is postponed or canceled for any reason and the psychotherapist cannot be notified at least 1 week in advance, then a fee of **$750.00** will be charged to reimburse the psychotherapist for time set aside for the testimony. agree to pay photocopying charges of **$.75/page** for copies of any records or reports that the psychotherapist is requested or required to produce, including by subpoena.

I agree that my obligation to compensate the psychotherapist as stated above will be the same whether I or any other party involved in any legal matter request or require the psychotherapist's involvement or testimony, and agree that my obligation to pay the psychotherapist as stated in this agreement will not be affected by the service of any subpoena on the psychotherapist.

I understand that my paying the psychotherapist for time for legal involvement does not mean that the psychotherapist will serve as an expert witness, nor does it mean that the psychotherapist's involvement will be of help to me in any legal action. This agreement will continue in existence and continue to be binding on me even after my treatment with the psychotherapist ends. This agreement will be enforceable in court.

Signature of Patient _____ Date:_____

Print Patient Name: _____ Date:_____

TELEMEDICINE INFORMED CONSENT FORM

I/We_____(patient/s) hereby consent to engaging in telemedicine with Penny Siegmann, LCSW-R (the "psychotherapist") and/or Kenneth Beiner, LMSW and/or Rosie Carino, LMSW (the "psychotherapist") as part of my psychotherapy. (Kenneth Beiner, LMSW is supervised by Joanna Suppa, LCSW-R, Rosie Carino, LMSW is supervised by Penny Siegmann-Beiner LCSW-R, and both are employed by Penny Siegmann, LCSW-R.).

I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment using interactive audio-video communications. I also understand that, with my signed consent, telemedicine may involve the electronic communication of my medical/mental healthcare information to other health care practitioners. The rights stated supplement those rights I have generally as a patient of the psychotherapist.

I understand that I have the following rights with respect to telemedicine:

I have the right to withhold or withdraw consent to telemedicine treatment at any time.

The laws that protect the confidentiality of my medical/healthcare information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are mandatory exceptions to confidentiality, including reporting child abuse and the imminent risk of danger to self or others. If I put my mental state at issue in certain legal proceedings, then the psychotherapist may be compelled to release otherwise confidential information about my evaluation and treatment.

I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that the transmission of my medical information could be interrupted or distorted by technical failures or unauthorized persons, and that the electronic communication of my medical information could be accessed by unauthorized persons.

I understand that telemedicine-based services and care may not be as complete or effective as face-to-face services. I also understand that if my psychotherapist believes I would be better served by in-person psychotherapeutic services, I will be referred to a psychotherapist who can provide such services in my area. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

As with all medical records, I understand that I have a right to access my medical information and copies of medical records of telemedicine treatment in accordance with New York State law.

I have read and understand the information provided above. I have discussed it with the psychotherapist, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment.

_____ _____

Patient (or Parent/Guardian) Signature Date

_____ _____

Print Name of Patient (or Parent/Guardian) Date

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLKLUNG (ID#) OTH (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? PLACE (State) YES NO

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.

PATIENT AND INSURED INFORMATION

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 MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

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.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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	

PHYSICIAN OR SUPPLIER INFORMATION

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. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

FORM #511-12 01(Rev 02/12)

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Please include a copy of your Insurance Card – front and back.

Patient Request for Confidential Communications

We would like to identify the methods of communication that you prefer (e.g., phone, text, email). Please remember electronic communications such as voicemails, texts or emails are unencrypted and may be neither secure nor confidential.

If there is a significant issue, please DO NOT use email or text; rather, please leave a detailed voicemail message, and we will get back to you as soon as possible. Of course, if it is an emergency, please call 911. We place a high priority on getting back to our clients in a timely fashion. Therefore, if you do not hear back from us in at least 24 hours, then we probably didn't get the message. Unfortunately, phone systems periodically have problems, so please keep that in mind and kindly call again.

I wish to be contacted as follows **(Please check all that apply)**:

□ At my home number: _____
- □ You can leave messages with detailed information
- □ Leave message with call-back number only

□ At my cell phone number: _____
- □ You can send texts with detailed information
- □ You can text regarding scheduling only
- □ You can leave message with call-back number only
- □ Send texts only re: _____

□ In writing at:
- □ My home address:_____
- □ My email address:_____

□ Instead of paper copies, please send correspondence, bills and reports to my email address:
_____

_____ _____
Signature of Patient (or Parent of Minor) Date

_____
Print Name