Valerie L. Braunstein, Psy.D.
255 S. 17th Street
Suite 1106
Philadelphia, Pennsylvania 19103
(267) 712-9217
drvaleriebraunstein@gmail.com

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to my practice. This document (The Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (The Notice) for use and disclosure of PHI for treatment, payment and health care operations. This Notice Form, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures during our session.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use 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 we talk about both during our 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 has also been shown to have many benefits. 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.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you impressions of what our 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 me. Therapy involves a commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions above my procedures we should discuss them whenever they arise.

SESSIONS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to

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meet you or your child's treatment goals. If psychotherapy is begun, I will usually schedule one, 50-minute session per week or every other week at a time we agree on, although some sessions may be longer or more frequent**. Once an appointment session is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation or unless we both agree that you were unable to attend due to circumstances beyond your control.**

PROFESSIONAL FEES

The per session fee for Dr. Braunstein is $170.00.You will be expected to pay for each session at the time it is held by credit card, check, or cash. Clients are expected to pay the session fee at the end of each session unless other arrangements have been made. Each appointment lasts approximately 50 minutes. In addition to regular appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods less than one hour. Other services include report-writing, assessment, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. **Please be aware that some of these services will not be covered by your insurance and you will be responsible for the fees.** If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs. Because of the difficulty of legal involvement, we will charge more per hour for preparation and attendance at any legal proceeding.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail. I will make every effort to return your non-emergency call within 48 hours, with the exception of weekends and holidays. If you are unable to reach me and believe you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call, or dial 911. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.
Please do not use email or faxes for emergencies. I do not always check my e-mail daily.

E–MAILS, CELL PHONES, COMPUTERS, AND FAXES

It is very important to be aware that computers and unencrypted e-mail, texts, and e- faxes communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. While my computers are password protected, e-mails and e-fax are not encrypted. It is always a possibility that e-faxes, texts, and email can be sent erroneously to the wrong address and

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computers. Voicemail messages are kept confidential as well, and accessed only by myself or another licensed psychologist that covers my practice in my absence.

Please notify me if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phones calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, 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. Please do not use texts, e- mail, or faxes for emergencies.

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can release only information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I believe that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- If a patient seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

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- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If a patient files worker's compensation claim, I must, upon appropriate request, provide records relating to treatment or hospitalization for which compensation is being sought.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have cause to believe that a child who I am evaluating may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), the law requires that I make a report to the appropriate governmental agency, usually the Department of Public Welfare. Once such a report is filed, I may be required to provide additional information.

- If I have reason to believe that an elderly person or other adult is in need of protective services (regarding abuse, neglect, exploitation, or abandonment), the law allows me to report this to appropriate authorities, usually the Department of Aging, in the case of an elderly person. Once such a report is filed, I may be required to provide additional information.

- If I believe that one of my patients presents a specific and immediate threat of serious bodily injury regarding a specifically identified or a reasonably identifiable victim and he/she is likely to carry out the threat or intent, I may be requires to take protective actions, such as warning the potential victim, contacting the police, or initiating proceedings for hospitalization.

If such a situation arises, I will make every effort to fully discus it with you before taking any action and I will limit my disclosure to what is necessary.

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 now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

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PROFESSIONAL RECORDS

The law and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone. Except in unusual circumstances that involve danger to yourself and/or others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon your request.

In addition, I may or may not also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the content of our conversations, my analysis of those conversations, and how they impact you in therapy. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including companies without your written, signed Authorization.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of Protected Health Information. These rights include requesting that I amend your record, requesting restrictions on what information from your Clinical Record is disclosed to others, requesting an accounting of most disclosures of Protected Health Information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached notice form, or any of my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is my policy to request an agreement from the patient and his/her

parents that the parents consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communications will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment.

LITIGATION LIMITATION

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

INSURANCE

For insurance carriers that I am in-network (e.g., Highmark Inc.) or accept (e.g., Aetna Student Health - Aetna Health and Life Insurance Company), I will fill out and submit forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. 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, I will provide you with whatever information I can, based on my 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, I 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" plan 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 much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, you have the option of paying for my services on your own or I will do my best to find another

provider who will help you continue your psychotherapy. You should also be aware that your contract with your health insurance company requires that you authorize me to provide it with information relevant to the services that I provide to you. If you are seeking reimbursement for services under your health insurance policy, you will be required to sign an authorization form that allows me to provide such information. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. 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, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, 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 sessions. It is important to remember that you always have the right to pay for my services by yourself to avoid the problems described above (unless prohibited by contract).

Not all issues/conditions/problems, which are dealt with in psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. Depending on the individual situation, therapy may or may not continue until unpaid balances are paid in full.

TERMINATION

As set forth above, after the first several meetings, I will assess if I can be of benefit to you. If I do not believe it is in the clients' best interests to work with someone who, in my opinion, I cannot help. In such a case, if appropriate, I will give you referrals that you can contact. If at any point during psychotherapy I either assesses that I'm not effective in helping you reach the therapeutic goals or it appears that your responses to my therapeutic approach are not optimal for your well-being, I will discuss with you the termination of treatment and conduct pre-termination counseling. In such a case, if appropriate and/or necessary, I would give you referral to at least one other provider. If you request it and authorize it in writing, I will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, this can be discussed and the best course of action decided jointly. You have the right to terminate therapy at any time. If you choose to do so, upon your request and if appropriate and possible, I will provide you with names of other qualified professionals whose services you might prefer.

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PENNSYLVANIA NOTICE FORM

Notice of Psychologist' Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to the information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
  - -*Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *-Payment* is when I obtain reimbursement for your health care. Examples of payments are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - -*Health Care Operations* are activities that relate to the performance an operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

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II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

▪ **Child Abuse:** If I have reasonable cause, on the basis of my professional judgment, to suspect abuse of children with whom I come into contact in my professional capacity, I am required by law to report this to the Pennsylvania Department of Public Welfare.

▪ **Adult and Domestic Abuse:** If I have reasonable cause to believe that an older person is in need of protective services (regarding abuse, neglect, exploitation or abandonment), I may report such to the local agency which provides protective services.

▪ **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release the information without your written consent, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

▪ **Serious Threat to Health or Safety**: If you express a serious threat, or intent to kill ϖ seriously injure an identified or readily identifiable person or group of people, and I

determine that you are likely to carry out the threat, I must take reasonable measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.

▪ **Worker's Compensation:** If you file a worker's compensation claim, I will have to file periodic reports with your employer which shall include, where pertinent, history, diagnosis, treatment, and prognosis.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

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Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will provide you with a copy of the version.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have concerns about your privacy rights, I will be more than willing to discuss these concerns.

If you believe that your privacy rights have been violated and wish to file a complaint with me/my office, you may send your written complaint to the U.S. Department of Health and Human Services. I will provide you with this address upon your request.

VI. Restrictions and Changes to Privacy Policy

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If I revise my policies and procedures, I will provide you with a notice of the revised policies and procedures at such time.

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I affirm that Dr. Braunstein has provided me with copies of the above "Psychotherapist-Patient Services Agreement" and the attached "Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information." I have read both forms carefully, understand all policies and agree to comply with them:

_____
Patient's Name (print)

_____
Legal Guardian Name (print)

_____ Date_____
Patient Signature

_____ Date_____
Legal Guardian Signature

_____
Psychotherapist's name (print)

_____ Date_____
Psychotherapist's Signature

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NEW PATIENT INFORMATION

Date:_____

Patient Name:_____
Last First M.I.

SSN:_____-_____-_____

Address:_____

City:_____State:_____

Zip:_____

Home Phone:(____)_____-_____ Work Phone:(____)_____-_____

Ext:_____

Cell Phone: (____)_____-_____

E-mail: _____

Is it OK to call and leave a message at these numbers and e-mail address:
☐ yes ☐ no

Gender: [ ] Male [ ] Female

Date of Birth:_____-_____-_____

Age:_____

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed
[ ] NA (child)

Employment Status: [ ] Employed [ ] Student [ ] Disabled [ ] Employed/student
[ ] Unemployed

Employer (or)
School:_____

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Insurance Company:_____

Referral Source:_____

Permission to thank referral source? (circle one): Yes or No

Referral Type: [ ] self [ ] family [ ] spouse [ ] friend [ ] physician [ ]

EAP [ ] work [ ] court [ ] school [ ] internet

[ ] other _____

Primary Care Physician: _____

Phone:_____

Permission to communicate with PCP about your treatment? (circle one): Yes or No

In Case of Emergency, Contact:

Name:_____

Relationship:_____

Phone:_____

For children & adolescents only:
Parents marital status: ☐never married ☐married ☐separated ☐divorced ☐widowed

[ ] Mother (or Guardian) [ ] Father

Name:_____ _____

Address: _____

_____

_____ _____

_____ _____

(H) Phone: _____

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(W) Phone: _____

Custody Arrangement (for divorced/separated parents):
☐informal (no court order) ☐ joint legal custody ☐ sole legal custody (mother)
☐ sole legal custody (father) ☐ other:_____

Primary residence of child is with: _____

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E-MAIL and SMS CONSENT FORM

Purpose: This form is used to obtain your consent to communicate with you by email or SMS regarding your protected health information (PHI).

Dr. Braunstein offers patients the opportunity to communicate by e-mail or SMS. Transmitting patient information by e-mail or SMS has a number of risks that patients should consider before granting consent to use e-mail or SMS for these purposes.

Dr. Braunstein will use reasonable means to protect the security and confidentiality of e-mail and SMS information sent and received. However, Dr. Braunstein cannot guarantee the security and confidentiality of e-mail or SMS communication and will not be liable for inadvertent disclosure of confidential information.

Patient's Acknowledgment and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of e-mail or SMS between Dr. Braunstein and myself. I consent to the conditions outlined herein. Any questions I may have had were answered. I agree and consent that Dr. Braunstein may communicate with me regarding my protected health information by e-mail or SMS.

Patient signature: _____

Date: _____

Patient Name: _____

Patient Address: _____

Patient E-mail Address: _____

Patient Cell Phone Number: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I _____, born on _____, hereby authorize:

Valerie L. Braunstein, Psy.D.
255 S. 17th Street
Suite 1106
Philadelphia, Pennsylvania 19103
610.952.6725

To release and/or obtain, the following information in ☐my records ☐my child's records:

- ☐ Mental health and medical history, including diagnosis
- ☐ Records of outpatient treatment
- ☐ All diagnostic, psychological assessment
- ☐ Academic records including grades and standardized testing scores
- ☐ Other: _____

This information is to be ☐ released to ☐ obtained from:

_____

_____

_____

_____

This information is to be released for the following purpose(s):

Treatment planning & coordination of care
At the request of the individual, parent or authorized agent
Forensic Evaluation – I understand that my authorization to release the results of the evaluation may present favorable or unfavorable implications related to the assessment findings and/or recommendations. I have been informed of the risks pertinent to participation in a forensic evaluation during my initial appointment. {Initials: _____}
☐ Other: _____

I understand that I have the right to revoke consent to future disclosure in writing at any time,

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however this revocation will not be effective to the extent that I have already taken action in reliance on this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment generally may not be conditioned on signing a release of information, unless the services are provided to me for the purpose of providing information to a third party. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this information and no longer protected by the HIPPA privacy rule. I acknowledge that I have had the opportunity to discuss and ask questions about issues concerning privacy and confidentiality and this consent.

This is authorization will remain in effect from _____until _____ unless otherwise revoked in writing at a future point in time.

_____ _____
Signature Date

_____
Printed Name

_____ _____
Signature of Witness Date

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CREDIT CARD PRE-AUTHORIZATION FORM

I authorize Dr. Valerie Braunstein to keep my signature on file and to charge the credit card selected below for the following:

Balance remaining for:

This consultation only

All consultations this calendar year

All consultations from _____ to_____

Recurring charges in the amount of $_____to be charged every session

From_____to _____
(date) (date)

Charges for the following family members:

_____
(authorized family member)

_____
(authorized family member)

Check One:

Visa
MasterCard
Discover Card

Valerie L. Braunstein, Psy.D.
255 S. 17th Street
Suite 1106
Philadelphia, Pennsylvania 19103
(267) 712-9217
drvaleriebraunstein@gmail.com

Patient Name:

_____

Cardholder Name:

_____

Cardholder Address:

_____

City: _____

State: _____

Zip: _____

Credit Card Number: _____

Exp. Date: _____

Security Code: _____

Cardholder Signature: _____

Date: _____