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PATIENT INFORMATION

Last Name: ____

First Name: ____

Date of Birth: _________ / _________ / _________

Physical Address: _______________________________________ Apt. _____

City: _________________________________ State: _____ Zip: ____________

Billing Address: ____ Apt. ______

City: _________________________________ State: _____ Zip: ____________

Cell Phone: (_______) _________ - ______________

Email address: ____

Emergency Contact Name: ____

Emergency Contact Phone: (_______) _________ - ______________

Credit Card information for file:

Number: ___________________________________ Security Code: ________

Expiration: _____/______ Zip Code Associated with account: __________________

(Please note credit cards may be used for payment. However, there will be a 3.5% upcharge, due to the fee the credit card reader charges merchants. This upcharge cannot be billed to your insurance carrier.)

CANCELLATION POLICY:

There will be a 24 hour cancellation policy. Patients that cancel their appointments in less than 24 hours will be billed and held responsible for said appointment. If the patient and therapist are able to reschedule said appointment within the same week of the cancellation, then the rescheduled appointment will be charged as usual.

CONFIDENTIALITY (as defined by the NASW code of ethics):

"Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed. Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client."

PAYMENT AND HEALTH INSURANCE:

Payment for the initial consultation is due at the end of the consultation. Thereafter, the therapist will provide a monthly bill at the end of every month. Payment in full is expected at that time or within the following two weeks. These bills will be prepared to meet the health insurance company's criteria. Payment directly from the insurance company will not be accepted. Cash, check and credit card payment (with an additional 3.5% charge) are accepted.

EATING DISORDER CLIENTS:

Clients will be required to obtain medical, psychiatric and/or dental care, if the therapist assesses that these services are medically and clinically indicated.

YOUR PRIVACY (as defined by the NASW:

"Your health record contains personal information about you and your health. This 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, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices."

EMAIL:

Please note that email interactions are not private and secure. Email may only be used to send blank forms and to schedule appointments.

I have read and accept the policies outlined in this form:

CLIENT SIGNATURE:________________________________DATE:____________