Lucie M. Taustine, Ph.D.

218 Granny Road
Farmingville, NY 11738
Phone: 516.799.3320 Fax: 516.453.6798

PATIENT INFORMATION AND CONSENT FOR TREATMENT

Title: Dr./Mr./Ms./_____ First Name_____ Last Name_____
Circle one or indicate other

Home: Street Address _____

Town or City, State, ZIP _____

Phone Numbers: Home _____ Cell _____

May messages be left at your home? _____On your cell's voice mail? _____

May I send you text messages on your cell phone? _____

E-mail I may use to correspond with you _____

With whom do you live? _____

What is your occupation? _____

Name of company where you work _____

Phone number at work _____ May I call work?_____

Birth date _____ Age _____ Marital Status _____Legal gender _____

Preferred Pronouns He/His/Him She/Her/Hers They/Them/Theirs _____
Circle one or indicate other

Source of Referral _____

Who is your regular physician? _____

Address/Phone Number _____

Name and phone number of nearest friend or relative (not living with you) who can be contacted in case of emergency _____

Have you had prior psychological, psychiatric, or other mental health treatment? _____

If so, when and with whom? _____

Primary Health Insurance Company _____

Policy Number _____ Group Number _____

Name of Insured _____ Date of Birth _____

Relationship to Patient _____

Insured's Employer _____

Secondary Health Insurance Company _____

Policy Number _____ Group Number _____

Name of Insured _____ Date of Birth _____

Relationship to Patient _____

Insured's Employer _____

I, _____, consent to psychotherapy/psychological assessment/pre-surgical evaluation/other mental health services_____ with Dr. Lucie M. Taustine. I understand that all information will be kept confidential within the limits of the law and technology. (Suspected child, elder, or animal abuse, imminent self-destructive behavior or violence planned against others, suicidal, or homicidal threats or plans are taken seriously and acted upon immediately.) I understand that I may be charged or any or all missed or late cancelled (less than 24 hours) appointments, as per the Cancelled and Missed Appointment Policy form and no future appointment will be scheduled except for emergency or urgent situations until the fees are paid. There will be a service charge of $25 plus bank fees for any returned check. I consent that all necessary information (which may include but not be limited to: name, address, additional demographic information, diagnosis, detailed clinical material, and dates and types of service) may be released to a HIPAA compliant billing service, the insurance company(ies) named above, and/or a collection agency and/or an attorney. I understand that I am responsible for payment in full unless there is a contract between Dr. Taustine and my insurance company. I understand that I am responsible for any and all deductibles, co-payments, and/or co-insurance. I understand that, if prior approval is required, I am responsible to obtain it, and failure to do so may make me responsible for payment in full. I understand if my insurance company denies payment due to an error on my part, or due to its cancellation, I am responsible for payment in full at the rate of $275 for the first appointment and $250 for subsequent 45-minute sessions (subject to change).

I understand that I must pay all fees, co-payments co-insurance, or other fees at the time of service or immediately upon receipt of an invoice.

I certify that any and all information I have provided is accurate, and understand that the use or attempted use of anyone else's health care insurance is fraudulent.

Signed _____ Date _____

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GENERAL PHYSICAL AND MENTAL HEALTH INFO AND HISTORY

Name _____

Date of birth _____ Gender (legal) _____

How would you describe your current physical health? Please circle or underline.
Excellent Very good Good Fair Satisfactory Poor Very poor

Please explain._____

Are you currently taking any prescribed or over-the-counter medications or vitamins/minerals/other supplements? _____

Please continue on another page if you need additional space.

Medication, dose, reason	Prescriber
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

How is your sleep? _____How is your appetite? _____

Do you have or have you had an eating disorder? _____ Please explain.
_____

What is your height? _____ What is your current weight? _____

How would you rate your current weight and general physical condition?
_____

Do you exercise? _____ Please describe your level of physical activity.
_____

Do you identify as a gender other than the gender you were assigned at birth? _____
If YES, please describe your gender identity. _____
How do you define your sexual orientation. _____

What is your marital/relationship status (please circle or underline):
Single Married Domestic partnership Divorced Separated Widowed

How do you describe your primary relationship, if you're in one?_____
_____

Do you live with one or more adults? _____ Names and relationships to you? _____

Do you have children? _____ Do they live at home? _____
Ages/names? _____

Do you smoke cigarettes or use other tobacco products? _____ Describe your use._____

Describe your current alcohol use. _____

Has alcohol ever had a negative impact on any aspect of your life? _____
Please explain. _____

Describe your current use of recreational drugs or prescription medications not taken as ordered. _____

Has drug use ever had a negative impact on any aspect of your life? _____
Please explain. _____

Is religion, faith, or spirituality an important part of your life? _____What religion do you practice? _____ How does it influence your life? _____

Are there any weapons in your home? _____ Do you feel safe having them there? _____ Is there any information about them you need for me to know? _____

Have you ever been the victim of violence (domestic, acquaintance, stranger, sexual assault)? _____ Please explain what happened and the outcome.
_____

If you are unsafe at home now, please do not indicate it in writing if it's possible for your abuser to find and see these forms.

Are you employed outside the home? _____

What is your job/career/profession? _____

Are you happy and/or satisfied with your employment? _____

Please list any hospitalizations (medical, surgical, obstetric, psychiatric, other) you have had. Please continue on another page if you need additional space.

Hospital	Reason	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you or any blood-related family member(s) experienced or been professionally diagnosed with any or the following disorders, events, diseases?

	Please circle	Family member
Addictions (alcohol, drugs, gambling, sex)	yes/no	_____
ADHD/ADD	yes/no	_____
Anxiety Disorder	yes/no	_____
Autism Spectrum Disorder/Asperger's	yes/no	_____
Bipolar Disorder (Manic Depressive)	yes/no	_____
Depression	yes/no	_____
Eating Disorder	yes/no	_____
Learning Disorder	yes/no	_____
Neurodivergent Condition (not ASD, ADHD)	yes/no	_____
Obsessive Compulsive Disorder (OCD)	yes/no	_____
Schizophrenia	yes/no	_____
Suicide attempt(s)	yes/no	_____

How far did you go in school? Please check one.

Did not complete high school _____
High school graduate _____
Some college _____ Field of study _____
Associates degree_____ Field of study _____
Bachelors degree _____ Field of study _____
Masters degree _____ Field of study _____
Doctoral degree _____ Field of study _____

What would you say are your personal strengths? _____

What would you say are your personal weaknesses? _____

How would you describe your (or your family's) financial situation? _____

What do you do for fun or enjoyment? _____

Signed _____ Date _____

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CONSENT FOR RELEASE OF PATIENT INFORMATION

Patient's Name _____

Complete Address _____

Phone Number (_____)_____ Date of Birth _____

I, _____, acting on behalf of _____,

do hereby give consent to the disclosure to/from Dr. Lucie M. Taustine to/from:

Name _____ Phone Number _____

Complete Address_____

Nature/extent of information to be disclosed: _____

Purpose or need for disclosure: _____

This consent shall be valid for one (1) year from the date of signed authorization or until it is revoked in writing, whichever comes first.

Signed _____ Date _____

_____
Signature and Printed Name of Witness

Dr. Lucie M. Taustine

218 Granny Road
Farmingville, NY 11738
Phone: 516.799.3320
Fax: 516.453.6798

CANCELLATION AND MISSED APPOINTMENT POLICY

I understand that I am responsible for payment for all missed or late-cancelled appointments (i.e., less than 24 hours). The fee for missed or late-cancelled appointments will be equal to EACH PATIENT'S full insurance fee per session (within the limits of the law and the contract I have with various insurance companies). This does NOT mean that one must pay his or her co-pay for a missed or late-cancelled session, but rather the entire insurance fee (i.e., co-pay plus what insurance pays). Payment must be made before the end of the month in which the missed session or cancellation occurs; otherwise, we will have to suspend treatment until payment is made. Only true emergency or crisis appointments will be scheduled while there is an outstanding balance.

Working virtually, my policy is that I will wait on Zoom until 15 minutes after our appointment was to begin, unless you have texted, emailed, or called to let me know you will be late. At that time, I will sign off and you will be changed for a missed appointment.

This policy is necessary because each person's appointment time is set aside for him, her, or them alone. No one else can be scheduled during that time, and if an appointment is missed or late-cancelled, it is wasted time.

My signature indicates understanding and acceptance of this policy.

Signed _____ Date _____

Lucie M. Taustine, Ph.D.

218 Granny Road
Farmingville, NY 11738
Office Phone/Text: 516.799.3320
DocLucie@gmail.com

INFORMATION ABOUT PAYMENT PROCEDURES

All deductibles, co-payments, co-insurance, and/or self-pay fees are billed via Ivy Pay, unless you do not have a credit, debit, or FSA/HSA account/card. Ivy Pay is a HIPAA compliant card processing platform, designed for mental health professionals. Please e-mail me if you don't have a credit/debit card, to make other arrangements.

Ivy Pay will send you (or whomever you designate) a bill/invoice via text, and you provide the necessary information. Initially, unless you already have an outstanding invoice/bill you will have a set-up charge of $1 (which will be refunded or deducted from your first bill) and after which you will have a card on file, allowing me to charge any appropriate fees on or about the days they are incurred (or when the Explanation of Benefits becomes available, informing me of your deductible, co-payment, and/or co-insurance*). This Ivy Pay enrollment (with the $1 charge) must be completed, along with the other paperwork, prior to our first appointment.* All fees (including missed/late cancelled charges, as per Consent for Treatment form) will be managed directly through Ivy Pay, without needing to be invoiced by my office. Neither my billing service nor I will have access to your credit/debit card information at any time. Any errors made on my part will be promptly rectified.

Once your Ivy Pay is established, and your annual deductible is satisfied/met (if you have one), I will not send Zoom links if balances are not paid in full. Of course, I will remain available for urgent/emergency situations, regardless of your financial status, as long as we are working together.

I appreciate your understanding and am humbled by your trust in me, and honored to participate in your healing journey.

Best,

Dr. Lucie M. Taustine, Ph.D.

LUCIE M. TAUSTINE, PH.D.
218 Granny Road
Farmingville, NY 11738
Phone: 516.799.3320 Fax: 516.453.6798

IVY PAY INFORMATION AND AUTHORIZATION

Patient's Name _____ _____
First Last

Person who is responsible for payment of your self-pay, deductible, co-payments, missed/late cancelled fees, and/or co-insurance:

_____

Relationship to patient _____

Cell phone number you are authorizing to be submitted to Ivy Pay for all treatment-related charges (as per consent for treatment)

(_____)_____

Signature _____

Date _____

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HIPAA PRIVACY NOTICE

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

2) We are required to abide by the terms of this Notice currently in effect.

3) We reserve the right to change the terms of the Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgment that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment, or health operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgment or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure. We will attempt in good faith to obtain your signed Acknowledgment that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, precertification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information without first obtaining your Acknowledgment or Authorization. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as is necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been

unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-related information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries or symptoms sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain rights regarding your health record information, as follows:

1) You may request that we restrict the uses and disclosures of your health record information, information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

3) You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access has been restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage and preparation or an explanation or summary of the information.

4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

6) If this Notice was initially provided to you electronically, you have the right to obtain a paper copy of this Notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to:

PRIVACY OFFICER
Dr. Lucie M. Taustine
218 Granny Road
Farmingville, NY 11738

The law requires that you acknowledge receipt of this notice.

Signed _____ Date _____

LUCIE M. TAUSTINE, PH.D.

218 Granny Road
Farmingville, NY 11738
Phone: 516.799.3320 Fax: 516.453.6798

AFFORDABLE CARE ACT (ACA)**

Due to issues which have arisen with insurance provided through the Affordable Care Act (AKA, "the marketplace" or "Obama care"), at any time, you may need to provide proof that your premiums have been paid during and throughout your treatment. If your insurance denies payment for services, due to non-payment of your premiums, you will become responsible for payment in full for your therapy. The current rate is $275 for your first appointment and $250 for subsequent 45-minute sessions (subject to change in writing).

_____ _____

Signature Date

_____

Print Name

** Only sign this form if your insurance is provided through the ACA. Thank you.