Live a Life by Design LCSW, PLLC

Staci Rosenberg, LCSWR, CEC
Psychotherapist & Life Coach

Patient Registration

Name _____ Date Of Birth_____

Preferred Name: _____ House #_____ Cell # _____

Address_____City_____ST_____ZIP_____

Email _____ Social Security # _____

Current Medications_____

Psychiatrist/Medical Doctor_____

Emergency Contact_____ Phone #_____

Relationship: _____ Address: _____

Patient Employer Information

Employer Name_____Occupation_____

Address_____Phone #_____

Insurance Information

Primary Insurance_____ ID#_____

Insurance Holder_____Relationship_____DOB_____

Secondary Insurance_____ ID# _____

Insurance Holder_____Relationship_____DOB_____

Authorization to Release Information and Assignment of Benefit

I authorize the release of any medical information necessary to process this claim electronically or by fax. I permit a copy of this authorization to be used in place of the original.

Date_____Signature_____

I hereby authorize Staci Rosenberg, LCSWR to apply for benefits on my behalf for covered services rendered by her. I request that payment from my insurance company be made directly to Staci Rosenberg, LCSWR. **If the insurance does not cover the rendered service, I am responsible for the payment.** I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original.

Date_____Signature_____

I understand if appointments are cancelled with less than 24 hours, I will be charged the full fee for the visit.

Date_____Signature_____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been implemented in this practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, text, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by Government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the Licensed Clinician.

6. Your confidential information will not be used for the purposes of marketing/advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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Signature on File

I authorize Live a Life by Design, PLLC to help obtain payment information from my insurance carrier(s). This includes my authorization to release information to my insurance company, use this form, or a copy of this form in place of the original, process all insurance submissions, and for my insurance carrier to directly reimburse Live a Life by Design, PLLC for services rendered with Staci Rosenberg, LCSW-R. I request payment be made directly to the clinician, Staci Rosenberg. I have reported with regard to my insurance cover is correct.

I understand that although Live a Life by Design, PLLC will help to process insurance claims, I am responsible for my bill. I permit a copy of this authorization to be used in place of the original.

Patient name	Signature	Date

Appointment/Cancellation/No Show Policy

Appointments

Office visits are by appointment only, please call 914-589-3588. Patients who are late for any appointment may be asked to reschedule at clinicians discretion.

Cancellations

We would like to thank you for being a patient in our office. We value all of our patients and strive to provide the best care possible in the most comfortable setting. Please understand that when we schedule your appointment, we are reserving time for you. We kindly ask that if you must change an appointment, please give us at least 24 hours' notice. This courtesy makes it possible to give your reserved time to another patient who would like it. We know that your time is valuable. When your appointment is made, the time is reserved for you. Except in the case of emergency treatment for another patient, you can expect us to be running on schedule. If you are unable to keep an appointment, we ask that you cancel at least 24 hours in advance. If this is not possible, please call as soon as you can so another patient can be given your appointment time.

Missed Appointments (Non-Cancelled)

We understand that occasional missed appointments can occur for a variety of reasons. We track missed (non-cancelled) appointments. A "No Show/Late Cancellations" is defined as missing an appointment without cancelling at least 24 hours before scheduled time. There will be a charge for a missed or non-cancelled appointment. Insurance will not cover charges for no show/late or cancellation fees. The first missed appointment there is no charge, however any addition will result in the patient being charged the full fee for their visits. This fee covers the administrative tasks associated with your appointment. This fee will need to be paid in full prior to seeing the clinician.

Payment

Payment is due in full at the time of service, no exceptions. The office accepts cash or card as a form of payment. For any card that is charged, there is a $3.00 convenience fee added.

Patient name	Signature	Date