

**LEONID REMENSON, MD PA, General Psychiatry & Psychopharmacology  
ANALOGY COUNSELING, Inc., Nanette Vitale, MSW, LCSW**

**PATIENT IDENTIFICATION (PLEASE PRINT):**

Date \_\_\_\_\_

( ) Dr. ( ) Mr. ( ) Mrs. ( ) Miss ( ) Ms.

NAME: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ APT. \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ EMAIL \_\_\_\_\_

HOME PHONE # ( ) \_\_\_\_\_ WORK PHONE # ( ) \_\_\_\_\_ MOBILE ( ) \_\_\_\_\_

**Which would you prefer as a reminder: automatic phone call \_\_\_\_\_ text message \_\_\_\_\_ both \_\_\_\_\_**

**If seasonal or temporary resident, please indicate other address on the reverse side of this page**

BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE#( ) \_\_\_\_\_

WHO REFERRED YOU TO THIS PRACTICE \_\_\_\_\_

**FINANCIAL RESPONSIBILITY**

GUARANTOR'S LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_

GUARANTOR'S ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER \_\_\_\_\_ EMPLOYER PHONE#( ) \_\_\_\_\_

List the name(s) and relationship(s) of those we may discuss **TREATMENT** and/or **FINANCIAL** matters with:

\_\_\_\_\_  
\_\_\_\_\_

**FINANCIAL INFORMATION**

ARE YOU SELFPAY?

NAME OF HEALTH INSURANCE COMPANY \_\_\_\_\_

**PHARMACY INFORMATION**

NAME: \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

ADDRESS OR CROSSROADS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

# PLEASE KEEP THIS FOR YOUR RECORDS

## *A NOTE TO OUR PATIENTS*

We would like to take this opportunity to highlight some of our routine office practices so that we can avoid misunderstandings in the future.

### 1) PRESCRIPTIONS:

If you are on medication, we generally prescribe ample medication to last until your next appointment. If you return for appointments as recommended, you should not run out of medicine. **Please remember that our office does not “call in” routine prescriptions to your pharmacy between appointments.** There should be enough medication on the previous prescription until the next scheduled appointment. Please note: If the doctor feels it is appropriate to call in prescriptions under exceptional circumstances, he can only do so during routine office hours. As we do not have access to our patients’ charts outside office hours, we do not feel the best medical care can be provided in this situation. Anytime you need to have a refill on a medication it is important to check if you are due for an appointment. You can check the status of any requested refills prior to the end of the working day.

### 2) AUTHORIZATIONS FOR MEDICATIONS:

Sometimes, your insurance company will not approve payment for a medication prescribed by Dr. Remenson, without a special authorization. For that purpose, your insurance may contact Dr. Remenson requesting to fill in forms in addition to a regular prescription that he has given you. To help you decrease your medication expenses, the doctor will do it for you. However, it takes doctor’s time. If it is done outside your appointment, there may be a charge for this activity in proportion with the time spent on it. In most cases, this service is not covered by your insurance.

### 3) CANCELLING APPOINTMENTS:

It is important that you call to cancel existing appointments at least a full business day in advance. A specific time is allotted for appointments. We’d like to accommodate all our patients, but when a patient misses an appointment, it keeps us from being able to help everyone. Therefore you will be charged for the time that was held for your appointment. We would rather not charge you and would rather utilize the time for other patients. Once again, remember that this is 24 business hours notice for Leonid Remenson, MD and 48 hours notice for Nanette Vitale, LCSW. The weekend is not included. You would need to cancel Monday appointment on the prior Friday morning in order for us to try to utilize this time. Please bear in mind that we cannot bill insurance for a missed appointment and that you will be responsible for the full normal fee (not just the co-pay), and that our normal fee may be higher than your insurance fee. **We will try but we cannot guarantee that we will be able to call you and remind of follow up appointments.**

### 4) EMERGENCIES:

Please call between appointments if any urgent clinical matters arise. If a clinical emergency or urgent situation arises, you can call 911, go to the nearest emergency room or leave a message on Dr. Remenson’s or Nanette Vitale’s voice mail, depending on the degree of urgency. If you chose to leave a message, your call will be returned as soon as possible.

AUTHORIZATION

I AUTHORIZE L.REMENSON, M.D., P.A. and/or ANALOGY COUNSELING, INC. TO RELEASE ANY PSYCHIATRIC OR MEDICAL INFORMATION NEEDED TO AUTHORIZE MY BENEFITS OR PAYMENTS TO THE DOCTOR FOR HIS SERVICES, TO MY INSURANCE COMPANY AND THEIR AGENTS, OR MEDICARE IF APPLICABLE. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND INSURANCE BENEFITS WILL BE MADE ON MY BEHALF TO L.REMENSON, M.D. P.A., AND/OR ANALOGY COUNSELING, INC. FOR SERVICES FURNISHED BY HIM.

**I UNDERSTAND THAT FAILURE TO KEEP A SCHEDULED APPOINTMENT OR CANCEL WITHOUT ONE FULL BUSINESS DAY NOTICE (24 HOURS) WILL RESULT IN THE FULL NORMAL FEE (which may be higher than my insurance fee).** I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY THE INSURANCE CARRIER. I UNDERSTAND I MAY NOT RECEIVE A CONFIRMATION CALL REMINDING ME OF MY VISIT AND THAT IT IS MY RESPONSIBILITY TO KEEP TRACK OF MY APPOINTMENT SCHEDULE.

I UNDERSTAND THAT IF THE CHARGES FOR SERVICES BY L.REMENSON, M.D., P.A. and/or ANALOGY COUNSELING, INC. ARE NOT PAID WITHIN 60 DAYS OF THE DATES OF SERVICE, I WILL BE CHARGED INTEREST ON A MONTHLY BASIS AT A RATE OF 18% ANNUALLY OR THE MAXIMUM ANNUAL INTEREST RATE PERMITTED, WHICHEVER IS LOWER. I HEREBY WAIVE CONFIDENTIALITY IF L. REMENSON, M.D., P.A. AND/OR ANALOGY COUNSELING, INC. REPORTS UNPAID SERVICES TO VARIOUS AGENCIES/COMPANIES, INCLUDING CREDIT REPORTING AGENCIES. SHOULD MY ACCOUNT BE TURNED OVER FOR COLLECTIONS, I WILL BE RESPONSIBLE FOR ALL COSTS OF COLLECTIONS AND/OR ATTORNEY'S FEES UP ACCESSED.

I HAVE RECEIVED A COPY OF THE **PRIVACY RULES**.

I HAVE RECEIVED AND ACCEPTED THE **NOTE TO OUR PATIENTS**.

I HAVE INFORMED L.REMENSON, M.D., P.A. and/or ANALOGY COUNSELING, INC. OF MY INSURANCE COVERAGE OR LACK THEREOF. I UNDERSTAND WITH INSURANCES CONSTANTLY CHANGING, I NEED TO VERIFY WITH MY INSURANCE COMPANY THAT I AM COVERED UNDER PSYCHIATRIC CARE. I UNDERSTAND THAT IF MY INSURANCE STATUS CHANGES, IT IS MY RESPONSIBILITY TO INFORM DR. REMENSON and/or ANALOGY COUNSELING, INC., AND THERE WILL BE NO REFUND OR REIMBURSEMENT OF THE FULL NORMAL FEE PAID TO DR. REMENSON FOR SERVICES PROVIDED UP TO THE DATE OF NOTIFICATION.

I GIVE MY CONSENT TO L. REMENSON, M.D., P.A., AND/OR ANALOGY COUNSELING, INC. AND TO MY PRIMARY CARE PHYSICIAN \_\_\_\_\_ (NAME) AND MY THERAPIST \_\_\_\_\_ (NAME) TO EXCHANGE THE INFORMATION AND RECORDS PERTAINING TO MY MEDICAL, PSYCHIATRIC AND SUBSTANCE ABUSE EVALUATION AND TREATMENT:

**MUST FILL AREAS BELOW**

Signed \_\_\_\_\_

Patient's name \_\_\_\_\_

Dated \_\_\_\_\_

**PLEASE CHECK PROBLEMS THAT YOU HAVE:**

**Immunologic/Allergy:**

- watery eyes
- Frequent infections
- Allergies
- Other
- No problems

**Breathing:**

- Cough
- Difficulty breathing
- wheezing
- other
- no problems

**Cardiovascular:**

- Palpitations
- Shortness of breath on exertion
- cramps when walking
- Gangrene
- Other:
- no problems

**General well-being:**

- Fatigue
- Fever
- unexplained weight loss
- other:
- no problems

**Skin/hair/nails:**

- Itchiness
- Rash
- Hair loss
- Other:
- no problems

**Endocrine:**

- Excessive thirstiness
- Excessive urination
- Other:
- No problems

**Ears/Nose/Throat:**

- Sore throat
- Hearing problem
- Runny nose
- other:
- no problems

**Reproductive system:**

- decreased sex drive
- Problems with erection
- No orgasm
- other:
- No problems

**Stomach:**

- Nausea
- constipation
- vomiting
- Heartburn
- Poor appetite
- Other:
- No problems

**Blood/lymph system:**

- Easy bleeding/bruising
- Lymph node swelling
- Other:
- No problems

**Musculoskeletal:**

- Joint swelling/pain
- Muscle aches
- Bone deformities
- Other:
- No problems

**Neurological:**

- Problems moving, paralysis
- Numbness/tingling
- Gait problems
- other:
- No problems

**Eyes:**

- Watery eyes
- blurred vision
- Need glasses
- Eye irritation
- other
- No problems

**GU:**

- Blood in urine
- difficulties./burning on urinating
- Female problems
- Incontinence
- other
- No problems

**Psychiatric (Check all that apply)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Problems falling asleep                   | <input type="checkbox"/> impulsivity (acting before thinking)  | <input type="checkbox"/> worrying excessively                            |
| <input type="checkbox"/> waking up too early                       | <input type="checkbox"/> short attention span                  | <input type="checkbox"/> having unreasonable or excessive fears          |
| <input type="checkbox"/> Problems concentrating                    | <input type="checkbox"/> feeling elated                        | <input type="checkbox"/> feeling that others are against you             |
| <input type="checkbox"/> sadness/depression                        | <input type="checkbox"/> restlessness/difficulty sitting still | <input type="checkbox"/> seeing things that others do not see            |
| <input type="checkbox"/> decreased interest in doing thing         | <input type="checkbox"/> Forgetfulness                         | <input type="checkbox"/> hearing voices                                  |
| <input type="checkbox"/> decreased enjoyment                       | <input type="checkbox"/> Impatience                            | <input type="checkbox"/> having a feeling that somebody is following you |
| <input type="checkbox"/> Self-reproach                             | <input type="checkbox"/> Distractibility                       | <input type="checkbox"/> Preoccupation with weight                       |
| <input type="checkbox"/> poor energy                               | <input type="checkbox"/> losing things often                   | <input type="checkbox"/> binge eating                                    |
| <input type="checkbox"/> wanting to die                            | <input type="checkbox"/> making careless mistakes when working | <input type="checkbox"/> Vomiting or using laxatives to lose weight      |
| <input type="checkbox"/> wanting to kill yourself                  | <input type="checkbox"/> problems organizing activities        | <input type="checkbox"/> starving yourself on purpose                    |
| <input type="checkbox"/> anxiety, nervousness                      | <input type="checkbox"/> putting off projects                  | <input type="checkbox"/> alcohol problem                                 |
| <input type="checkbox"/> Panic                                     | <input type="checkbox"/> feeling tense                         | <input type="checkbox"/> drug problem                                    |
| <input type="checkbox"/> Rituals or needing things to be "just so" | <input type="checkbox"/> interrupting people often             |  |
| <input type="checkbox"/> Obsessive thoughts/images                 | <input type="checkbox"/> talking excessively                   |  |
| <input type="checkbox"/> Anger problem                             | <input type="checkbox"/> having too much energy                |  |
| <input type="checkbox"/> Violence                                  | <input type="checkbox"/> not being able to relax               |  |
| <input type="checkbox"/> Thoughts of hurting others                |  |  |

NAME \_\_\_\_\_

WHY ARE YOU SEEING THE DOCTOR TODAY \_\_\_\_\_

**MEDICAL HISTORY**

ALLERGIES OR ADVERSE DRUG REACTIONS \_\_\_\_\_ NONE \_\_\_\_\_

MEDICATIONS (PLEASE LIST ALL THE MEDICATIONS INCLUDING ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS&SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MEDICATIONS TAKEN IN THE PAST THREE MONTHS: \_\_\_\_\_

\_\_\_\_\_

**HABITS:**

CURRENT USE

PAST USE

TOBACCO

\_\_\_\_\_

\_\_\_\_\_

ALCOHOL

\_\_\_\_\_

\_\_\_\_\_

RECREATIONAL DRUGS

\_\_\_\_\_

\_\_\_\_\_

**WEIGHT:** \_\_\_\_\_ lbs

**HEIGHT:** \_\_\_\_\_ ft \_\_\_\_\_ in

**ILLNESSES: (PAST AND PRESENT)**

HEART Y\_\_N\_\_

STROKE

Y\_\_N\_\_

BACK PAIN Y\_\_N\_\_

THYROID Y\_\_N\_\_

ANEMIA

Y\_\_N\_\_

CANCER Y\_\_N\_\_

GLAUCOMA Y\_\_N\_\_

REFLUX DISEASE

Y\_\_N\_\_

HIGH BLOOD PRESSURE

PROSTATE Y\_\_N\_\_

LIVER PROBLEMS

Y\_\_N\_\_

Y\_\_N\_\_

SEIZURES Y\_\_N\_\_

LUNG DISEASE

Y\_\_N\_\_

DIABETES Y\_\_N\_\_

ARTHRITIS

Y\_\_N\_\_

OTHER: \_\_\_\_\_

\_\_\_\_\_

**FEMALES ONLY:** ARE YOU PREGNANT? Y\_\_N\_\_ PLANNING TO GET PREGNANT? Y\_\_N\_\_

**PSYCHIATRIC HISTORY**

PREVIOUS PSYCHIATRISTS/THERAPISTS: \_\_\_\_\_ WHEN? \_\_\_\_\_

MEDICATIONS PRESCRIBED IN THE PAST? \_\_\_\_\_

PSYCHIATRIC HOSPITALIZATIONS? (DATES, REASONS) \_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY**

PSYCHIATRIC PROBLEMS, DRUG OR ALCOHOL PROBLEMS, SUICIDE ATTEMPTS IN BLOOD RELATIVES \_\_\_\_\_

\_\_\_\_\_

**Please be aware that all medications may have the potential to cause problems in pregnancy or with the developing fetus.**

# PLEASE KEEP THIS FOR YOUR RECORDS

Leonid Remenson, MD, PA & Analogy Counseling, INC

## Notice of Privacy Practices

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

Our vision is to provide quality health services in a caring manner. This includes taking measures to protect the confidentiality of your personal health information.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or healthcare operations and for other purposes permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and relate to your past, present or future physical or mental health or condition and related healthcare services.

We are required by law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information we maintain at that time. You may obtain the latest Notice of Privacy Practices by contacting L.Remenson, M.D., P.A., and or Analogy Counseling, INC., and requesting a revised copy be sent to you in the mail, or by asking for a copy at the time of your next appointment.

### HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT PATIENTS

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**For Treatment** We may use medical information about patients to provide patients with medical treatment or services. We may disclose medical information about your condition to a physician or other healthcare provider (e.g. a specialist or psychotherapist home care agency) who, at the request of your physician, becomes involved in your care. We may also disclose medical information occasionally to our outside transcriptionist to type up medical record entries or letters.

**For Payment** We may use and disclose medical information to obtain payment for treatment and services provided. For example, we may need to give a patient's health plan information about a therapy session performed by Dr. Remenson and or Analogy Counseling, INC., so the patient's health plan will pay us or reimburse the patient for the costs of the treatment. We may also tell a patient's health plan about a treatment that patients are going to receive, to obtain prior approval or to determine whether a patient's plan will cover the costs of the treatment.

**For health care operations:** In the course of providing treatment to patients, we may perform certain important functions such as quality assessment, training programs, credentialing, medical review etc. In performing such actions, we may rely on certain business associates to assist us. We will share with our business associates only the minimum amount of personal health information necessary for them to assist us. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes.

In the course of providing treatment, pursuing payment or operating our practice, we may use or disclose your health information for the following purposes:

**Appointment Reminder** To contact patients who have an appointment for treatment or evaluation by Dr. Remenson and/or Analogy Counseling, INC..

**Treatment Alternatives** To tell patients about or recommend possible treatment options or alternatives that may be of interest to patients.

**Health-Related Benefits and Services** To tell patients about health-related benefits or services that may be of interest to patients.

**Individuals Involved in a Patient's Care or Payment for a Patient's Care** We may release medical information about a patient to a friend or family member who is involved in a patient's medical care, with written permission from the patient. We may also give information to someone who helps pay for a patient's care with written permission from the patient or a copy of the power of attorney for the patient. In addition, we may disclose medical information about a patient to an entity assisting in a disaster relief effort so that a patient's family can be notified about a patient's condition, status and location.

**As Required By Law** We will disclose medical information about patients when required to do so by federal, state or local law.

**To Avert a Serious Threat to Health or Safety** We may use and disclose medical information about a patient when necessary to prevent a serious threat to a patient's health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

**Business associates:** We may share health information about our patients with business associates who are performing services on our behalf. For example, we may contract with a company to service and maintain our computer system, or do out billing. Our business associates are obligated to safeguard patients' health information. We will share without business associates only the minimum amount of personal health information necessary for them to assist us.

**SPECIAL SITUATIONS** The following special situations may result in additional uses and disclosures of health information by L.Remenson, M.D., P.A.:and/or Analogy Counseling, INC.,

**Military and Veterans** If a patient is a member of the armed forces, we may release medical information about that patient as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation** We may release medical information about patients for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

**Public Health Risks** We may disclose medical information about patients for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability. We will only make this disclosure if the patient agrees or when required by law.
- To report child abuse or neglect
- To report reactions to medications or problems with products (only patient's initials, not full name given)
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if the patient agrees or when required by law.

**Health Oversight Activities** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes** If patients are involved in a lawsuit or a dispute, we may disclose medical information about patients in response to a court or administrative order. We may also disclose medical information about patients in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We will do it only with the written permission of the patient or when required by law.

**Law Enforcement** We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process, with written permission from the patient or when required by law
- To identify or locate a suspect, fugitive, material witness, or missing person
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct
- About criminal conduct at Dr. Remenson's and/or Analogy Counseling, INC., practice.
- In emergency circumstances to report a crime, the location of a crime or victims, or the identity, description or location of the person who committed the crime
- To Children and Family Services

**Coroners, Medical Examiners and Funeral Directors** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of Dr. Remenson and/or Analogy Counseling, INC., to funeral directors as necessary to carry out their duties.

**National Security and Intelligence Activities** We may release medical information about patients to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Protective Services for the President and Others** We may disclose medical information about patients to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

#### OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with a patient's written permission. If patients provide us permission to use or disclose their medical information, patients may revoke that permission, in writing, at any time. If patients revoke their permission, we will no longer use or disclose medical information about patients for the reasons covered by the original written authorization. Patients understand we are unable to take back any disclosures we have already made with a patient's permission, and we are required to retain our records of the care we provided to patients.

#### PATIENT RIGHTS

Patients have the following rights regarding medical information maintained by L. Remenson, M.D., P.A., and/or Analogy Counseling, INC..

**Right to Request Restrictions** Patients may request a restriction or limitation on the medical information we use or disclose about patients for treatment, payment or healthcare operations. Patients also may request a limit on the medical information we disclose about patients to someone who is involved in a patient's care or the payment for a patient's care, like a family member or friend. For example, patients could ask that we not use or disclose information about a surgical procedure performed on the patient.

We are not required to agree to a patient's request. If we do agree, we will comply with a patient's request for restriction of use and disclosure. If the information is needed to provide emergency treatment or if it is determined that it is in the best interest of the patient to permit use and disclosure of protected health information, the request will be denied and health information will not be restricted. To request restrictions, patients must make a request in writing. In the request, patients must tell us (1) what information they want to limit; (2) whether they want to limit our use, disclosure or both; and (3) to whom they want the limits to apply, for example, disclosures to a patient's spouse. Dr. Remenson and/or Analogy Counseling, INC., has the right to request termination of the restriction at any time; the patient is required to agree to the termination either verbally or in writing.

**Right to Receive Confidential Communications** Patients have the right to request that we communicate with them about medical matters in a certain way or at a certain location. For example, patients can ask that we only contact them at work or by mail. To request confidential communications, patients must make a request in writing. A request must specify how or where they wish to be contacted.

**Right to Inspect and Copy** Patients have the right to inspect and copy medical information that may be used to make decisions about a patient's care for as long as the information is kept by or for L. Remenson, M.D., P.A. and/or Analogy Counseling, INC. Usually, this includes medical and billing records, but does not include psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding; or protected health information held by clinical laboratories if prohibited by the Clinical Laboratory Improvements Amendments of 1988 (CLIA).

To inspect and copy medical information that may be used to make decisions about patients, patients must submit a request in writing. If patients request a copy of the information we may charge a fee for the costs of copying, mailing or other supplies associated with a patient's request.

We may deny a patient's request to inspect and copy information in certain very limited circumstances. For example, if the patient is under the direct care and supervision of Dr. Remenson and/or Analogy Counseling, INC., it is determined that a review or inspection of the medical record may upset or harm the patient, the request can be denied. If patients are denied access to medical information, patients may request that the denial be reviewed.

**Right to Amend** If patients feel that medical information we have about them is incorrect or incomplete, patients may ask us to amend the information. Patients have the right to request an amendment for as long as the information is kept by or for L. Remenson, M.D., P.A. and/or Analogy Counseling, INC..

To request an amendment, a patient's request must be made in writing. In addition, patients must provide a reason that supports the request.

We may deny a patient's request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny a patient's request if patients ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the medical information kept by or for L. Remenson, M.D., P.A. and/or Analogy Counseling, INC..
- Is not part of the information which patients would be permitted to inspect
- Is accurate and complete

If your request for amendment is denied, we will notify you in writing along with the reasons for denial.

**Right to an Accounting of Disclosures** Patients have the right to request an "accounting of disclosures." This is a list of the disclosures that we made of medical information about patients beyond the uses and disclosures described in this notice. To request this list or accounting of disclosures, patients must submit a request in writing. A patient's request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The first list patients request within a 12-month period will be free. For additional lists, we may charge patients for the costs of providing the list.

**Right to a Paper Copy of This Notice:** Patients have the right to a paper copy of this notice. Patients may ask us for a copy of this notice at any time from L. Remenson, M.D., P.A. and/or Analogy Counseling, INC. at 561-638-9219.

#### COMPLAINTS

If a patient believes their privacy rights have been violated, patients may file a complaint with Dr. Remenson and/or Analogy Counseling, INC. or with the Secretary of the United States Department of Health and Human Services (HHS). To file a complaint with Dr. Remenson and/or Analogy Counseling, INC., submit the complaint in writing to his office. To file a complaint with the Secretary of HHS, the patient must contact the Office for Civil Rights directly (see Cont Analogy Counseling, INC., act Information below).

**Patients will not be penalized for filing a complaint. L. Remenson, M.D., P.A. and/or Analogy Counseling, INC., is committed to protecting an individual's rights under HIPAA and at no point will require an individual to waive their right to file a complaint as a condition of the provision of treatment.**

#### CONTACT INFORMATION

Leonid Remenson, MD  
Analogy Counseling, INC., Nanette Vitale, LCSW  
5350 W. Atlantic Ave, Suite 106  
Delray Beach, FL 33484  
561-638-9219

#### U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR)

Region IV - Atlanta (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee)  
Roosevelt Freeman, Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services  
Atlanta Federal Center, Suite 3B70  
61 Forsyth Street, S.W.  
Atlanta, GA 30303-8909  
Voice Phone (404) 562-7886 FAX (404) 562-7881 TDD (404) 331-2867  
<http://www.hhs.gov/ocr/>

PLEASE DO NOT STAPLE IN THIS AREA



**HEALTH INSURANCE CLAIM FORM**

PICA <span style="float: right;">PICA</span>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>					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 <input type="checkbox"/> F <input type="checkbox"/>				
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				
CITY			STATE		7. INSURED'S ADDRESS (No., Street)			CITY	
ZIP CODE		TELEPHONE (include Area Code)			CITY		STATE		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:				
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO				
b. OTHER INSURED'S DATE OF BIRTH MM   DD   YY      M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT?      PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO    _____				
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE				
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.					11. INSURED'S POLICY GROUP OR FECA NUMBER				
SIGNED <input checked="" type="checkbox"/> DATE _____					a. INSURED'S DATE OF BIRTH MM   DD   YY      SEX M <input type="checkbox"/> F <input type="checkbox"/>				
14. DATE OF CURRENT: MM   DD   YY					b. EMPLOYER'S NAME OR SCHOOL NAME				
17. NAME OF REFERRING PH					c. INSURANCE PLAN NAME OR PROGRAM NAME				
19. RESERVED FOR LOCAL U					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>				
21. DIAGNOSIS OR NATURE C					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.				
1. _____					SIGNED <input checked="" type="checkbox"/> DATE _____				
2. _____					14. PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM   DD   YY      TO    MM   DD   YY				
24. A					17. RESUBMISSION      ORIGINAL REF. NO.				
DATE(S) OF SER					19. LAB?      \$ CHARGES				
From MM   DD   YY To MM   DD   YY					S <input type="checkbox"/> NO				
CPT/HCPCS    MODIFIER    CODE					19. RESUBMISSION      ORIGINAL REF. NO.				
\$ CHARGES					19. AUTHORIZATION NUMBER				
DAYS OR UNITS					25. FEDERAL TAX I.D. NUMBER    SSN    EIN				
EPSDT Family Plan					26. PATIENT'S ACCOUNT NO.				
EMG					27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				
COB					28. TOTAL CHARGE      29. AMOUNT PAID      30. BALANCE DUE				
RESERVED FOR LOCAL USE					\$      \$      \$				
1					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.)				
2					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				
3					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #				
4					SIGNED      DATE				
5					PIN#      GRP#				
6					(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)				

PLEASE JUST SIGN  
HERE AND HERE  
NO NEED TO FILL THE REST  
(WE NEED TO HAVE YOUR SIGNATURE ON FILE TO BILL YOUR INSURANCE)