Dr. Joy Canfield, Licensed Clinical Psychologist, License No. 018056
Dr. Joy Canfield Psychology, Professional Corporation 420 Lexington Avenue, Suite 1402 - New York, NY 10170 Phone: 212-297-6115
JC@DrJoyCanfield.com www.DrJoyCanfield.com

PATIENT INFORMATION:

_____ _____ _____
Last Name First Name Middle Initial

_____ _____ _____ _____
Address City State Zip

_____ _____ _____ _____
Date of Birth Age Sex (Male or Female) Marital Status: (Single, Married, Divorced, Widowed)

_____ _____ _____
Telephone # Cell # Work #

_____ _____ _____
Driver's License # State e-mail address

_____
Name of Employer

_____ _____ _____ _____
Employer's Address City State Zip

_____

Referring Physician – Primary Care Physician

_____ _____
If Student, Name of School Attending Full or Part Time

If Student, has student authorization been obtained? ( ) yes ( ) no

SPOUSE INFORMATION, (if married)
RESPONSIBLE PARTY INFORMATION, (if patient is a minor)

_____ _____
Name Relationship to Patient

_____ _____ _____ _____
Address City State Zip

_____ _____ _____
Telephone Number Driver's License Number State

_____ _____
Responsible Party or Spouse Employer Work Number

_____ _____
Responsible Party or Spouse Employer's Address City State Zip

PATIENT EMERGENCY CONTACT INFORMATION:

_____ _____

Name Relationship to Patient

_____ _____

Telephone Number Cell Number

PRIMARY INSURANCE INFORMATION:

_____ _____

Name of Insurance Company Telephone Number

_____ _____ _____ _____

Insurance Company Claim Address: City State Zip

_____ _____

Group Number Certificate or ID Number

_____ _____

Policy Holder's Name Relationship to Patient: (Self / Spouse / Dependent

_____ _____

Policy Holder's Employer Employer Telephone Number

_____ _____ _____ _____

Policy Holder's Address City State Zip

_____ _____ Policy Holder's Date of Birth_____

SECONDARY INSURANCE INFORMATION:

_____ _____

Name of Insurance Company Telephone Number

_____ _____ _____ _____

Insurance Company Claim Address: City State Zip

_____ _____

Group Number Certificate or ID Number

_____ _____

Policy Holder's Name Relationship to Patient: (Self / Spouse / Dependent

_____ _____

Policy Holder's Employer Employer Telephone Number

_____ _____ _____ _____

Policy Holder's Address City State Zip

Policy Holder's Date of Birth _____

INSURANCE AUTHORIZATION:

I hereby assign, transfer, and set over to _____ (Practitioner's Name) all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

APPOINTMENTS
The keeping of regular appointments is the most effective means of successful therapy. As schedule permits, we will work out a most convenient time for you for these appointments. The scheduling of an appointment constitutes an agreement to pay for the professional time reserved exclusively for you. If an appointment must be canceled, please notify my office 24 hours or more prior to the appointment time. Insurance companies do not reimburse for cancelled/no-show appointments leaving the full balance to the client.

PAYMENT OF FEES
Payment is to be made in full at the time of service. We accept cash, check, MasterCard/Visa, and Discover. Payment of any unpaid balance on an account must be received in full before the close of the month. Payments are non-refundable. You will be charged a $25 service charge for all returned checks. Unpaid balances older than 60 days will be subject to collections proceedings.

CONSENT TO RELEASE OF INFORMATION
Client agrees to the constraints of confidentiality as outlined in the services agreement.

READ CAREFULLY AND SIGN
I have read, understand, and agree to comply fully with the above policies. I recognize and accept full financial responsibility for all professional services rendered.

Signature of Client / Date

_____

Signature of Office Staff or Psychologist

Dr. Joy Canfield, Licensed Clinical Psychologist, License No. 018056
420 Lexington Avenue, Suite 1402 - New York, NY 10170
Phone: 212-297-6115 National Provider Number: 1831333293

Medical History

Primary Care Physician

Name of Practice: _____ Doctor: _____

Address: _____ number: (___) ____ - _____

Past Diagnosis (please give the year)

1) _____

2) _____

3) _____

Current Medications (Include dosage and frequency)

1) _____ 2) _____

3) _____ 4) _____

Known Allergies: _____

_____

Severe Illness (childhood to present): _____

_____

Previous Counseling/Therapy

_____

_____

Stressors affecting you or your family in the past 1-2 years:

__Deaths __Job Change __Sexual Abuse __Births __School __ Work __Broken Relationship __Marriage __Step-Children __Unwanted Pregnancy __Divorce __Separation __Substance Abuse __Moving __Physical Abuse __Medical __Chronic Illness

Reason for Visit: _____

_____

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PSYCHOTHERAPY & CONSULTATION SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us. Please note that the rather formal legal language is based on the psychology association's suggestions. Our dialogues will undoubtedly be far less rigid and formal!

DR. CANFIELD'S PSYCHOTHERAPY SERVICES

Psychotherapy procedures vary depending on the personalities of the therapist and client and the specific concerns that you bring forward. As a psychologist and businessperson, Dr. Canfield combines her interests and studies in each of these areas in an effort to assist you in designing a plan to achieve your goals. There are many different methods that your therapist may use to deal with the objectives and concerns that you hope to address. Regardless of the methods used, the collaboration with your therapist will call for a very active effort on your part. During the collaborative work, you may experience some stress as you and your therapist work through the facets of your life that you would like to address. Alternatively, this work has been shown to have benefits for people who go through it which often leads to better relationships, solutions to specific problems, and growth as you build your plan to achieve your objectives. Though there are no guarantees in any personal or professional growth consultation, the goal is for you to become your own counselor who you will rely on in both your professional and personal life.

MEETINGS

Our initial 1 to 3 sessions will include a discussion of your individual and professional priorities, your strengths, and any obstacles that are occurring. During this time, we can both decide if I am the best person to provide the services you need in order to meet your goals. Thereafter, we will usually schedule one 50-55 minute session per week at a time we agree on. These meetings may be less frequent as we continue our work together.

PROFESSIONAL FEES

Psychologists are required to establish a standard fee for service. If you choose to pay out of pocket, our initial consultation has a fee of $250 with sessions thereafter being $175 per session. Clients using their insurance will be billed according to the contracted rate within their coverage if our sessions are in network. Some insurance policies have a deductible to meet prior to the standard co-pay. In addition to weekly 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 of less than one hour. Other services include report writing, telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records or summaries, and the time spent performing any other service you may request of me. ***Please note although unlikely, if you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement disruption to other clients' appointments, my office charges $175 per hour for preparation and attendance at any legal proceeding. Please inform your attorney of this. Thankfully these circumstances are rare.***

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree to an alternative plan. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client's consultation sessions is his/her name, the nature of services provided, and the amount due. Our 24 hour cancellation policy: Remember, insurance companies do not reimburse for cancelled/no-show appointments leaving the full balance to the client.

CONTACTING ME

I am often not immediately available by telephone. While I am usually in my office between 9 AM and 9 PM, I probably will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by a receptionist or voicemail. You are also welcomed to email me. While all provisions of confidentiality and encryption If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist on call. (Please be aware that there are inherent confidentiality risks in communicating by email. While safeguards are in place to ensure your privacy, you should not use email communication if you are concerned about any breaches of privacy that may inadvertently occur. Contact via email implies acceptance of this risk and acknowledgment of informed consent.)

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. In all facets of my work, I will keep records of our interactions. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about our work together. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I am required to file a report with the appropriate state agency. If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client 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. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

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 at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney. You will find additional information pertaining to confidentiality issues and the treatment of your records in the Notice of Policies and Practices to Protect Privacy statement.

CONSENT FOR PSYCHOTHERAPY TREATMENT

I, (patient name)_____, authorize and request that Joy Canfield, PhD provide examinations, treatment and/or diagnostic procedures which now or during the course of my care as a patient are advisable. The frequency and type of treatment will be decided between my therapist and me.

- ❑ I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement.
- ❑ I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur.
- ❑ I understand that maximum benefit will occur with consistent treatment compliance including attendance and that I should discuss any concerns about my care openly with my therapist or other appropriate professional or administrative person.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Signature of Client/Responsible Party and Date

_____

Signature of Office Staff or Psychologist

_____

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To my clients:

The below information addresses the criteria for mutual protection of visitors to our office. These points of protection have been carefully identified by the psychology profession alongside the health requirements of the CDC and the state of New York. It is certainly written in formal language – please know that I am very happy to discuss any of your concerns and we will adapt and adjust as much as we can! --Dr. Canfield

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS
--Developed by the American Psychological Association (APA)

This document contains important information provided by the ethics of the psychology profession with the primary focus of protection of all. The detailed information and requests relate to the mutual decision to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face
The psychology community as well as our office suite is carefully examining decision to meet in the office. Prior to this time, we have the option to meet with telepsychology, using the telehealth platform. This is an encrypted, HIPPA compliant application that offers a virtual therapy forum. Once we have agreed to meet in person for some or all future session, we may indeed return to virtual session, based on the criteria considered for your protection. Should a resurgence of the pandemic or if other health concerns arise, however, we may be required to meet exclusively via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is a concern that we may also need to discuss.

Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [my other staff] and other clients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- ❑ You will only keep your in-person appointment if you are symptom free. ___
- ❑ You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee. __
- ❑ You will wait until no earlier than 5 minutes before our appointment time. ___
- ❑ You will wash your hands or use alcohol-based hand sanitizer when you enter the building. ___
- ❑ You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.___
- ❑ You will wear a mask in all areas of the office (I [and office staff] will too). ___
- ❑ You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me [or staff]. ___
- ❑ You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. ___
- ❑ You will take steps between appointments to minimize your exposure to COVID. ___
- ❑ If you have a job that exposes you to other people who are infected, you will immediately let me [and office staff] know. ___

- ❑ If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and office staff] know. ___
- ❑ If a resident of your home tests positive for the infection, you will immediately let me [and office staff] know and we will then [begin] resume treatment via telehealth.___

The above precautions have been established by the APA and may change if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that I am committed to keeping you, me, [office staff] and all of our families safe from the spread of this virus. If you come to the GrayBar Building for an appointment and I [or my office staff] believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate. The GrayBar Building has implemented a temperature check method that simultaneously assesses large groups, and notifies staff if a person has a temperature of 100.4 or above. This procedure protects all who visit or work in the building.

If I [or office staff] test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____ _____
Patient/Client Date

_____ _____
Psychologist Date

Office Safety Precautions in Effect During the Pandemic

My office is taking the following precautions to protect our patients and help slow the spread of the coronavirus.

- Office seating in the waiting room and in therapy/testing rooms has been arranged for appropriate physical distancing.
- Office staff and I wear masks.
- Office staff maintains safe distancing.
- Restroom soap dispensers are maintained and everyone is encouraged to wash their hands.
- Hand sanitizer that contains at least 60% alcohol is available in the therapy/testing rooms, the waiting room and at the reception counter.
- We schedule appointments at specific intervals to minimize the number of people in the waiting room.
- We ask all patients to wait in their cars or outside until no earlier than 5 minutes before their appointment times.
- Credit card pads, pens and other areas that are commonly touched are thoroughly sanitized after each use.
- Physical contact is not permitted.
- Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis.
- Common areas are thoroughly disinfected at the end of each day.

SECURITY AT THE GRAYBAR BUILDING

As you visit the GrayBar building, the security staff will request that you present your ID and sign in to the registry. You are welcome to indicate that you are visiting Suite 1402 or NYC Office Suites. You are also welcome to indicate that you are coming to visit me. As I meet with many individuals for many purposes, there is an understanding that our appointments are confidential and with varied objectives.

It will ease this process to be included on the list of visitors – your reason for the visit will not be indicated. If you are comfortable with being included on the list of visitors to Suite 1402, please sign below.

I am also happy to come down to the main floor to meet you upon your arrival, if you prefer. You are welcome to call the front desk of Suite 1402 to let them know that you have arrived.

I appreciate your patience in supporting the efforts of the building to maintain security. Hopefully it will be an easier and smoother means of visiting the building. Thank you again.

Sincerely,
Dr. Joy Canfield

_____

Your name and date

(Signature approving inclusion to the Suite 1402 list of visitors)

Dr. Joy Canfield, Licensed Clinical Psychologist, License No. 018056

420 Lexington Avenue, Suite 1402 - New York, NY 10170

Authorization to Disclose Protected Health Information to Primary Care Physician or Other Medical Provider

Communication between your behavioral health provider(s) and your primary care physician (PCP) or other medical provider(s) is important to make sure all care is complete, comprehensive, and well coordinated. This form allows your behavioral health provider(s) to share valuable information with your PCP. No information will be released without your signed authorization

Section 1. The Patient

Last Name	First Name	Middle Initial

I hereby authorize the disclosure of protected health information about the individual named above.

I am: ☐ the individual named above (complete Section 8 below to sign this form)

☐ A personal representative since the patient is a minor, incapacitated, or deceased (Complete Section 9 below)

Section 2. Who Will Be Disclosing Information About the Individual?

Provider Name Joy Canfield, Ph.D

Section 3. Who Will Be Receiving Information About the Individual?

Physician Name:

Section 4. What Information About the Individual Will Be Disclosed?

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis, and medication(s) if necessary.

Section 5. The Purpose of the Disclosure

To release behavioral health evaluation and/or treatment information to the PCP to ensure quality and coordination of care.

Section 6. The Expiration Date or Event

This authorization shall expire one year from the date of signature below unless revoked prior to that date.

Section 7. Important Rights and other Required Statement You Should Know

- ❖ You can revoke this authorization at any time by writing to the practice listed above. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- ❖ The information disclosed based on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- ❖ You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services.
- ❖ This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- ❖ You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may request a copy at any time by contacting the practice listed above.

Section 8 Signature of the Individual

Signature Date(required)

Section 9. Signature of Personal Representative (if applicable)

Signature Date(required)

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

For Office Use Only

To Primary Care Physician:

Date First Seen

Diagnosis

Medications

Treatment Recommendations:

- ❑ Individual Therapy
- ❑ Family Therapy
- ❑ Group Therapy
- ❑ Medication Management
- ❑ Substance Abuse Treatment
- ❑ Couples Therapy
- ❑ Other