Dr. Jan Roberts & Associates

1115 Broadway, Suite 1194
New York, NY 10010
917.283.9700

Date:_____

Patient Name:_____

How did you hear about us? (Select one or more, if applicable)

_____ Psychology Today
_____ Facebook
_____ Google
_____ Other Internet (Specify:_____)
_____ Family Member/Relative
_____ Friend
_____ Existing Client
_____ Insurance Company/EAP
_____ Physician (Specify: _____)
_____ Other (Specify: _____)

==========

Client's Emergency Contact-

Name: _____

Phone Number: _____

Email: _____

Relationship to Client: _____

Dr. Jan Roberts & Associates

Consent to Treatment

Thank you for choosing Dr. Jan Roberts and Associates as your healthcare partner. In order to provide you with quality care, we believe that healthy boundaries are important. We have a number of client expectations about the professional relationship we embark on with each client. This consent to treatment outlines these expectations.

- We expect you to keep your appointments. Please remember that someone else may want this time. Please give our other clients and your clinician the courtesy of a 24 hour notice if you must cancel an appointment; otherwise, you will be charged our standard cancelation rate of $125.00. We always consider broken appointments individually and understand that emergencies do arise. Insurance will not pay for broken appointments. However, as a general rule of thumb, 3 broken appointments within a 6 month time period may result in discharge from our practice.

- Payment for your session is due at the time of service. We accept cash, personal checks, and credit cards. We work with a number of insurance companies via managed care contracts and we are responsible for filing claims for our services; you must pay your co-pay at the time services are rendered. There are no exceptions. Other insurance plans (out of network) are accepted but you may be required to pay the difference.

- **Our current fees are the following.**

  - **Psychotherapy (55 minutes): $250 per session**
  - **No show fee/same day non-emergency cancellation: $125**

- We also charge for our time when you require written correspondence. This is billed according to the amount of time utilized with a minimum fee of $20. This would include correspondence such as letters to other practitioners, disability applications, etc. Insurance will not pay for correspondence.

- Telephone consults are also billed at regular rates. The first 5 minutes we consider a professional courtesy to our relationship; thereafter, the time is billed at regular rates to the nearest quarter hour. Sessions are generally 55 minutes in length. Our clinicians take a few minutes between clients to relax, let go of the last session and prepare for the next one.

- Our clinicians will keep confidential anything you say with the following exceptions: a) you direct the therapist to speak about you with someone, b) The therapist determines that you are a danger to yourself or others, or c) there is evidence of child or elder abuse. In the event of the latter two exceptions, the therapist will contact family, friends, DFS and/or law enforcement authorities to attempt to prevent harm from coming to anyone.

- Our clinicians attend peer consultation with colleagues regularly. They may discuss the work occurring in your session in these sessions while maintaining your anonymity.

- ***If you are in a life and death emergency situation, dial 911 for assistance or go immediately to your local emergency department.***

I do hereby seek and consent to take part in the treatment provided by this agency. I am aware that I (or my child) may stop treatment with Dr. Jan Roberts & Associates at any time. I am aware that an agent of my insurance company or other third-party may be given information about the type(s), cost (s), and providers of any services I receive. I understand that if payment for the services I receive here is not made, Dr. Jan Roberts & Associates may stop treatment.

My signature below shows that I understand and agree with all of these statements. I have been given the opportunity to ask questions regarding this information.

_____ _____

Signature of Client (or person acting for client) **Date**

Relationship to Client: _____

I, the staff member, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of Staff Member **Date**

Policies and Practices to Protect the Privacy of Your Health Information

Effective/Last Revised Date: January 1, 2020

HIPPA and CONFIDENTIALITY INFORMATION

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Partners in Health and Wellbeing is required by federal law to protect the privacy of your health information in the context of your mental health and substance abuse health care administered by this agency. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice.

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it in our agency office or on the website.

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
  - Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another Therapist. Another example would be when we release your treatment plan to your insurance company and/or to your primary care physician.
  - Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

HOW WE USE OR DISCLOSE INFORMATION
We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);

- To the Secretary of the U.S. Department of Health and Human Services, if necessary, to ensure that your privacy is protected; and Where required by law.

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes we have made about your conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization
We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- **To process** claims for health care services you receive.

- **For Treatment.** We may disclose health information to your doctors or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your general health.

- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health related products and services.

- **To Referral Sources.** If you are referred through another agency such as your Primary Care Physician, Juvenile Court, DFCS, Psychiatric Hospital, CMHC, etc., we may share summary information and admission and discharge information with the referral source. In addition, we may share other health information with the referral source for case management purposes if the referral source agrees to special restriction on its use and disclosure of the information.

- **For Appointment Reminders.** We may use health information to contact you for appointment reminders with providers who provide medical or mental health care to you.

We may use or disclose PHI ***without your consent*** or authorization in the following circumstances under limited circumstances:

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.

- **For Public Health Activities** such as reporting disease outbreaks.

- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including social service or protective service agencies. If we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority. If we have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, we must report that belief to the appropriate authority.

- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations. If we are the subject of an inquiry by the Georgia Composite Board, we may be required to disclose protected health information regarding you in proceedings before the Board.

- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena. If you arc involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such information

is privileged under state law, and we will not release information without your written consent, subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.
  Serious Threat to Health or Safety. If we determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.

- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

- F**or Workers Compensation** including disclosures required by state workers compensation laws relating to job-related injuries. We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets all privacy law requirements.

- **To Provide Information regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

- **For Organ Procurement Purposes.** We may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.
  If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law.

If none of the above reasons applies, **then we will obtain your written authorization to use or disclose your health information.** If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information, as described below. Once you have given us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based upon your authorization. To revoke an authorization, contact the phone number listed below on this notice.

HIGHLY CONFIDENTIAL INFORMATION

Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal law governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- *Right to Request Restrictions* — You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing therapists. On your request, we will send your bills to another address.)

- *Right to Inspect and Copy* — You have the right to inspect or obtain a copy (or both) of PHI in your mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process. Your therapist may also deny access to your Clinical Notes.

- *Right to Amend*— You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

- *Right to an Accounting* — You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.

- *Right to a Paper Copy* — You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Clinician's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

- If we revise these policies and procedures, we will notify you by mail or on your next session. You may obtain a copy of this notice at the local office or website.

V. Complaints

If you have any questions about this notice or want to exercise any of your rights, please call 917-983-2700. Please specify that your question or concern is in reference to your mental health and/or substance abuse protected health information. Filing a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us at the following address:

Business Manager
RE: Compliance – Privacy
Dr. Jan Roberts & Associates
1115 Broadway, 11th floor
New York, NY. 10010

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any adverse action against you for filing a complaint.

VI. Cancellation Policy

In the event of an emergency, you will not be charged for session cancellation. Cancellations for any other reasons that are not received by clinic staff at least 24 hours prior to the scheduled session will be billed at the standard cancellation rate. Your insurance company will not pay for missed appointments.

VII. Financial Responsibility

Our office will assist you in completing and filing any insurance forms, which may be utilized for payments for services; however, you maintain full responsibility for paying all charges for services rendered. You will need to provide all required insurance information when checking in for services and you will need to update any changed insurance information immediately upon the date of change. All co-payments and unsatisfied deductibles are to be paid at the time of services rendered. does accept payment by cash or check.

VIII. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 18, 2017. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain.

IX. Patient's Consent

I consent for my therapist to disclose my protected health information (PHI) as required by my insurance company. Furthermore, if my insurance company requires coordination of care with my Primary Care Provider (PCP), I consent for my therapist to disclose my protected health information to my PCP. I have read this statement of the office's practices and policies and I both understand and approve of its content.

_____ Printed Name of Client

_____ Signature of Client and/or Guardian

_____ Date

_____ Witness Signature of Staff Member

Authorization for Release of Information for the Office of Jan Roberts, LCSW

(fill out only if necessary)

Patient Name: _____ **Date of Birth:** _____
Phone Number: _____

I authorize the Partners in Health and Wellbeing to provide patient information to:	I authorize the Partners in Health and Wellbeing to obtain patient information from:
Name of Provider or Facility	Name of Provider or Facility
Address	Address
City, State, Zip Code	City, State, Zip Code
Phone/Fax (include area code)	Phone/Fax (include area code)

Purpose of this request: (check one) Healthcare Insurance Personal Other

Type of Records Authorized: Psychiatric/Psychological Evaluation and/or Treatment
Drug/Alcohol Evaluation and/or Treatment

Specific Information Authorized: (select one or more, if applicable)

Assessments Progress Notes Diagnostic Impression

Discharge Summary Treatment Plans Treatment Summary

Other: (please describe)

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. **My authorization will expire:**

Upon information transfer 90 days from this date Other:

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.

My authorization will expire:

Upon cessation of services One year from this date Other:

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a *written* request to Partners in Health and Wellbeing, except where a disclosure has already been made in reliance on my prior authorization.
- If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- If the medical record information is not sent to another care provider, there may be a charge of the requested records.

Signature of Patient or Representative: _____ Date: _____

Relationship to Patient (*if requester is not the Patient)*: Parent Legal Guardian Other:

Credit Card Authorization Form

We require the collection of payment at the time of service. You may pay by check, cash or credit/debit card. If you intend to pay by credit/debit card, please fill out this form and return it with your paperwork. Your credit/debit card number is securely stored in our electronic patient record system and will be securely encrypted on your patient billing record. At each session, your card will automatically be charged unless you choose to pay for your session with another form of payment.

Payment Information-

Client Name:_____

Name on the Card: _____

Card Number: _____

Exp. Date: _____

Sec. Code (last 3-4 numbers on back of card's signature panel): _____

Billing Address Associated with Card: _____
(including Zip code) _____

Email Address: _____

I agree to allow Dr. Jan Roberts & Associates to charge my credit/debit card for payments or services received. I understand that this agreement can be revoked by me at any time in writing. All of my information will remain confidential.

Signature: _____