Patient Registration Information

Please fill out completely BEFORE being seen and sign the form.
Please have your: Insurance Card, Driver's License (Requirement for Insurance verification), and copay ready. Thank you!!

Is your condition a result of a work injury? Yes No An Auto Accident? Yes No Date of injury?

Name_____ **SS#**_____-_____-_____ **Marital Status** _____ **Gender** _____ **Date of Birth** _____/_____/_____

Address_____ **City**_____ **State**_____ **Zip Code**_____

Home Phone _____ **Other Phone** _____ **Email Address:** _____

Employer_____ **Employer Address**_____

Responsible Party

Responsible Party Name_____ **Social Security #** _____

Relationship to Patient _____ **Spouse** _____ **Parent** _____ **Guardian** _____ **Other** **Birth Date** _____/_____/_____

Address _____**Home Phone** _____

Employed By: _____

Primary Insurance

Carrier_____ **ID #** _____ **GRP #** _____

Mental Health Co - pay _____ **Secondary Insurance** _____

Emergency Contact Name_____ **Phone**_____ **Referred By** _____

Referring Physician _____

OFFICE BILLING AND POLICIES:

Consent for Treatment: I authorize and request _____ to conduct (1) a diagnostic evaluation; (2) treatment; (3) other clinical procedures which are advisable during the course of my/my dependent(s) care.

Release of Information: I authorize the release of medical and any other information for claims, outpatient treatment reports, certification, case management, quality improvement, collections and other purposes related to the benefits of my health plan. I authorize office communication to be left on my phone via voicemail, text message (confirmation or scheduling, etc) and/or via email.

Assignment of Benefits and Payment: I assign and transfer to _____ all payments and medical benefits from government agencies, insurance carriers, and others for the services rendered to me and/or my dependents(s). I permit a copy of this and/or a copy of an insurance form to be used in place of the original. I permit _____to bill for services electronically. All fees including co-payments, co-insurance or deductible amounts are collected at the time of service. There is a $25.00 service charge for all returned checks. In the event that my insurance company rejects the claim or does not pay in full (or contracted rate) for services rendered, I am responsible for payment in full (or contracted rate). I am aware that I am responsible for notifying my therapist of any insurance coverage changes, or of any secondary insurance coverage and that failing to notify may result in owing payment in full.

Cancelled/Missed Appointments: There is a **24-HOUR CANCELLATION POLICY** that requires you to cancel your appointment **24 HOURS IN ADVANCE** between the hours of 8am to 4pm Monday –Friday to avoid being charged up to the full session fee, which will be collected in full at or before your next appointment.

Forensic Services: **Any legal matter**, including but not limited to, civil, criminal, family, or drug court is beyond the scope of routine mental health care and is subject to full compensation at the rate of $300.00 per hour payable before services are rendered. In the instance a practitioner is subpoenaed, $1.095.00 is due per day, payable 30 days prior to the scheduled court appearance.

Mandated Reporting: Practitioners are mandated to report to the authorities patients who are at imminent risk of harming themselves or others for the purpose of those authorities checking to see whether such patients are owners of firearms, and if they are, or apply to be, then limiting and possibly removing their ability to possess them; in addition to notifying local authorities and any intended victim. With patients at imminent risk of harming themselves, significant others and the police may be contacted without the patient's consent if they can assist in preserving the patient's life.

Minors: Minors under the age of 16 cannot be left unattended at any time while on the premises of: 191 Broadway Amityville NY 11701. Parents or guardians are to remain in the waiting room until the completion of the therapy appointment.

I have been informed of and received a copy of the HIPAA privacy practices for this practice.

Name_____ **Signature**_____ **Date**_____

(Patient/Parent/Guardian)

Request for Electronic Communications

Name:_____

Date of Request: _____

D.O.B: _____

I request that the following communications from the practice of South Bay Counseling, LCSW PC /Elissa Grunblatt, "The Practice", be delivered to me by the provided electronic means. I understand that this form of communication may not be secure, creating a risk of improper disclosure to unauthorized individuals. I am willing to accept that risk, and will not hold the practice responsible should such incident occur.

___ Appointment reminders/changes

___ Communications which I, the client initiate

___ Other (list specifically) _____

Method

___ Email _____

___ Text and cell number _____

Time period for this method:

___ Until termination

___ Other _____

Acknowledgement and Agreement: I understand and agree that the requested communication method is not secure, making any PHI I, the client, include in such communications, at risk for receipt by unauthorized individuals. I accept the risk and will not retaliate against the practice in any way should this occur.

_____

Printed Name

_____ _____

Signature Date

_____ _____

Personal representative signature Address

_____

City, State, Zip Code

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

NOTICE OF PRIVACY PRACTICES

The following is the Notice of Privacy Practices of _____ at South Bay Counseling, LCSW, PC. HIPAA is a federal law that requires professionals to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy policies with respect to your protected health information (PHI). We are required by law to abide by the terms of this Notice of Privacy Practices.

Your Protected Health Information (PHI)

Your protected health information, or PHI, broadly includes any health information, oral, written, or recorded, that is created or received by me, other health care providers, and health insurance companies or plans, that contain data such as your name, address, social security or patient identification number and other information that could identify you as the individual who is associated with that health information.

Rules on How I May Use or Disclose Your Protected Health Information

Generally, I may not "use" or "disclose" your PHI without your permission, and must use or disclose your PHI in accordance with the terms of your permission. "Use" generally refers to activities within our office. "Disclosure" generally refers to activities involving parties outside of our office. The following includes a list of circumstances under which I am permitted or required to use or disclose your PHI. In all cases, I am required to limit such use or disclosure to the minimal amount of PHI that is reasonably required.

Without Your Written Authorization, Treatment, Payment and Health Operations

Without your written authorization, I may use within our office, or disclose to those outside of our office, your PHI in order to provide you with treatment you require or request, to collect payment for our services, and to conduct other related health care operations as follows:

Treatment Activities include: (a) use within our office by professional staff for the provision, coordination, or management of your health care at our office; and (b) our contacting you to provide appointment reminders or information about treatment alternatives or other health related services that may be of interest to you.

Payment activities include: (a) if you initially consent to treatment using benefits of your contract with your health insurance plan, I will disclose to your health plans or plan administrators, or their appointed agents. PHI for such plans or administrators to determine coverage, for their medical necessity reviews, for their appropriateness of care reviews, for their utilization review activities, and for outside billing companies and claims processing companies with which I have Business Associate Agreements that protect the privacy of your PHI; and (c) disclosures to attorneys, courts,

collection agencies and consumer reporting agencies, pf information as necessary for the collection of our unpaid fees, provided that I notify you in writing prior to our making collection efforts that require disclosure of your PHI.

Health Care Operations Include: (a) use within our office for training of our professional staff and for internal quality control and auditing functions (b) use within our office for general administrative activities such as filing, typing, etc., and (c) disclosures to our attorney, accountant, bookkeeper, and similar consultants to our healthcare operations, provided that I shall have entered into Business Associate Agreements with such consultants for the protection of your PHI.

PLEASE NOTE THAT UNLESS YOU REQUEST OTHERWISE, AND I AGREE TO YOUR REQUEST, I WILL USE AND/OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION FOR TREATMENT ACTIVITIES, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS AS SPECIFIED ABOVE, WITHOUT WRITTEN AUTHORIZATION FROM YOU.

Without Your Written Authorization, Special Situations and As Required By Law

In limited circumstances, I may use or disclose your PHI without your written authorization an in accord with HIPAA or as required by law. *Examples include:* (a) disclosures regarding reports of child abuse or neglect, including reporting to social service or child protective service agencies; (b) disclosures to state authorities of imminent risk of danger presented by patients to self or others for the purpose of restricting patient access to firearms; (c) health oversight activities including audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, or other lawful process; (e) to the extent necessary to protect you or others from a serious risk of imminent danger presented by you; (f) for worker's compensation claims; (g) as required by the Secretary of Health and Human Services to investigate or determine your compliance with federal regulations, including those regarding the government programs providing public benefits; (h) for research projects where your PHI has been de-identified, that is no longer identifies you by name or any other distinguishing marks, and cannot be associated with you; (i) to family members, friends and others involved in your care only if you are present and give oral permission for me to do so.

Minimum Necessary Rule

I will use or disclose your PHI without your authorization for the aforementioned purposes only to the extent necessary, and will release only the minimum necessary amount of PHI to accomplish the purpose.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required as described above, I may not use or disclose your PHI without your written authorization. Written authorization is required, among other uses and disclosures for (1) most uses and disclosures of Psychotherapy Notes, (2) uses and disclosures for

marketing purposes, (3) uses and disclosures that involve the sale of PHI and (4) other uses and disclosures not described in this Notice. Furthermore, I am required to use or disclose your PHI consistent with the terms of your authorization. You may revoke your authorization to use or disclose any PHI at any time, except to the extent that I have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy. I will not sell your PHI or use your PHI for paid marketing or fundraising purposes without your written authorization; I do not plan to use your PHI in marketing or fundraising.

Special Handling of Psychotherapy Notes

"Psychotherapy Notes" are defined as records of communications during individual or family counseling which may be maintained in addition to and separate from medical or healthcare records. Psychotherapy notes are only released with your specific written authorization except in limited instances, *including;* (a) if you sue me or place a complaint, I may use Psychotherapy Notes in our defense; (b) to the United States Department of Health and Human Services in an investigation of our compliance with HIPAA; (c) to health oversight agencies for a lawful purpose related to oversight of our practice; and (d) to the extent necessary to protect you or others from a serious imminent risk of danger presented by you. Health insurers may not condition treatment, payment, enrollment, or eligibility for benefits on obtaining authorization to review, or on reviewing, Psychotherapy Notes.

Your Rights With Respect To Your Personal Health Information

Under HIPAA, you have certain rights with respect to your PHI. The following is an overview of your rights and our duties with respect to enforcing those rights.

Right to Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your PHI. While I am not required to agree to any requested restriction, if agree to a restriction, I am bound not to use or disclose your protected healthcare information in violation of such restriction, except in certain emergency situations. I will not accept a request to restrict uses or disclosures that are otherwise required by law. If you have paid for services in full, independently of insurance, out- of-pocket, then I must comply with your request to restrict those disclosures of your PHI that would otherwise be made for payment or healthcare operations that are unnecessary due to the manner of your payment. I require that all requests for restrictions be in writing and specify (1) the information to be restricted, (2) the type of restriction being requested, and (3) to whom the limits apply. You must also state a reason for the request. I will respond in writing to all requests within 30 days of receipt.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations

I must permit you to request and must accommodate reasonable requests by you to receive communication of PHI from me by alternative means or at alternative locations. I will ask you how you wish me to communicate with you. I must agree to your request if you inform me that certain means of communicating with you will place you in danger.

Right to inspect and Copy Your Protected Health Information, Including in Electronic Format

You have the right of access in order to inspect, and to obtain a copy of your PHI, including any PHI maintained in electronic format, *except for* (a) personal notes and observations of the treating provider, (b) information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding, (c) health information maintained by me to the extent to which the provision of access to you is at our discretion, and I exercise our professional judgment to deny you access, and (d) health information is maintained by me to the extent to which the provision of access to you would be prohibited by law.

I require written requests for copies of your PHI; they should be sent to our Privacy-Security Officer at the mailing address below. You may request your PHI in the format of your choice, and where feasible, I will comply. If you request a copy of your PHI, I will charge a fee for copying, or for electronic records, for labor and supplies. I reserve the right to deny you access to and copies of all or certain PHI as permitted or required by law. Upon denial of a request for access or request for information. I will provide you with a written denial specifying the basis for denial, a statement of your rights, and a description of how you may file an appeal or compliant.

Right to Amend Your Protected Health Information

You have the right to request that I amend your PHI, for as long as your medical record is maintained by me. I have the right to deny your request for amendment. I require that you submit written requests and provide a reason to support the requested amendment.

If I deny your request, I will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with me and/or the Secretary of the US Department of Health and Human Services (DHHS). If I accept your request for amendment, I will make reasonable efforts to provide the amendment within a reasonable time to persons identified by you as having received PHI of yours prior to amendment and persons that I know have the PHI that is the requests for restrictions be in writing and specify (1) the information to be restricted, (2) the type of restriction being requested, and (3) to whom the limits apply. You must also state a reason for the request. I will respond in writing to all requests within 30 days of receipt. All requests shall be sent to our Privacy-Security Officer at the mailing address provided in this notice.

Right to Receive an Accounting of Disclosures of Your PHI and Electronic Health Records

You have the right to receive a written accounting of all disclosures of your PHI for which you have not provided an authorization that I have made within the (6) six year period immediately preceding the date on which the accounting was requested. You may request an accounting of such disclosure for a period of time less than (6) six years from the date of the request. I require that you request an accounting in writing on a form that I will provide to you.

The accounting of disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, instead of such statement, a copy of your written authorization or written request for disclosure pertaining to such

information. *I am not required to provide accountings of disclosures for the following purposes:* (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) to other healthcare providers involved in your care, € for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/2003. I reserve the right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. I will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to our Privacy-Security Officer at the mailing address provided in this notice.

If I maintain any PHI in electronic form, then you may also request and receive an accounting of any disclosures of your electronic health record made for purposes of treatment, payment and health operations during the prior three (3) year period. Upon request, one list will be provided for free every twelve (12) months.

Right to Notification if There is a Breach of Your Protected Health Information

If there is a breach in our protecting your PHI, I will follow HIPAA guidelines to evaluate any circumstances of the breach, document our investigations, retain copies of the evaluation, and where necessary, report breaches to DHHS. Where report is required to DHHS, I will also provide you with notification of any such breach.

Business Associate Rule

Business associates are entities that in the course of our business with them will obtain access to your PHI. They may use, transmit, or view your PHI on our behalf. Business associates are prohibited from re-disclosing your PHI without your written consent, or unless disclosure is required by law. I enter into confidentiality agreements with our business associates called business associate agreements, and they in turn enter into confidentiality agreements with their subcontractors, if any.

Complaints

You may file a complaint with me and with the Secretary of the Department of Health and Human Services (DHHS) if you believe that your privacy rights have been violated. Please submit ant complaint to me in writing by mail to our Privacy-Security Officer at the mailing address below. A complaint must name the subject of the complaint and describe the facts or omissions believed to be in violation of the applicable requirements of HIPAA or this Notice of Privacy Practices. A complaint must be received by me or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint. To file a complaint with the Secretary of DHHS, write or call:

Region 2 - New York (New Jersey, New York, Puerto Rico, Virgin Islands)
Linda Colon, Regional Manager
Office for Civil Rights

U.S. Department of Health and Human Services
Jacob Javits Federal Building
26 Federal Plaza - Suite 3312
New York, NY 10278
Voice Phone (800) 368-1019
FAX (212) 264-3039
TDD (800) 537-7697

You can also file a complaint electronically using the government portal at the following web address: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf Or you may submit a complaint packet received on the above listed website to the following email address: OCRComplaint@hhs.gov

Amendments to This Notice of Privacy Practices

I reserve the right to revise or amend this Notice of Privacy Practices at any time. These revisions or amendments may be made effective for all PHI I maintain even if created or received prior to the effective date of the revision or amendment. Upon your written request, I will provide you with notice of any revisions or amendments to this Notice of Privacy Practices, by mail, or electronically within 60 days of receipt of your request.

Ongoing Access to Notice of Privacy Practices

I will provide you with a copy of the most recent version of this notice at any time upon your written request sent to our Privacy-Security Officer at the mailing address below. For any other requests or for further information regarding the privacy of your PHI, and for information regarding the filing of a complaint, please contact me at the address, telephone number or email address listed below.

To Contact Me:

My Privacy Security Officer Is_____. My mailing address is: 191 Broadway, Amityville, NY 11701. My telephone number is: 631-264-0058 Fax: 631-264-0056.

Acknowledgement of Receipt of Notice of Privacy Practices of:

_____

I hereby acknowledge that I have received the Notice of Privacy Practices of the above practice.

_____ _____

Patient Signature Date

_____

Print Name

OFFICE USE ONLY:

Acknowledgement of Receipt of Notice of Privacy Practices was not obtained from

_____ Due to:

_____ Patient Refusal

_____ Lack of understanding

_____ Emergency

_____ Other: Specify

Therapist Name: _____

Date: _____