Western New York Psychotherapy Services
Carissa C. Uschold-Klepfer, LCSW-R

CONSENT FOR TREATMENT AND HEALTH CARE OPERATIONS

I, _____, hereby authorize, Carissa C. Uschold-Klepfer, LCSW-R and his/her business associates to provide treatment and carry out healthcare operations, including billing. The specific operations are:

a.) Billing 3rd party insurances.
b.) Sending self-pay bills to your home.
c.) Utilizing administrative staff to carry out operations that are necessary to maintain schedules and charts.
d.) Verifying insurance eligibility.
e.) Contacting insurance companies for authorization to begin and to extend number of sessions.
f.) Contacting insurance companies and primary care physicians to obtain referrals.
g.) Allowing your insurance company to review your file, including chart notes.
h.) Other: _____.

This consent form will be in effect for a period of no more than 3 years or when all communications with third parties for payment are completed, whichever occurs first. I understand that my records are protected under the Health Insurance Portability and Accountability Act (HIPAA) and cannot be disclosed without my written consent. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as described above or on the following date: _____ .

Signature of Client: _____ Date: _____

Signature of Guardian: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Please complete this form so that we may coordinate your care with your family doctor or other treating physician. If you DO NOT want us to communicate with your family doctor or treating physician, then please sign declination box at the bottom of this page.

Patient Name: _____ **DOB:** _____

I hereby authorize Carissa C. Uschold-Klepfer, LCSW-R to disclose information to:
DOCTOR/AGENCY: _____
ADDRESS: _____
PHONE/FAX NUMBER: (P)_____ (F) _____ _____
INFORMATION TO BE RELEASED:

_____ My involvement in treatment, dates & attendance.
_____ Treatment notes and/or treatment summary.
_____ Diagnosis & treatment recommendations.
_____ Assessment reports.
_____ Medical Record (i.e., notes, diagnoses, medications & medication compliance).
_____ My full record (i.e., chart notes, summaries, assessments, reports, observations, etc.)
_____ Other: _____ .

This information is disclosed for the purpose of coordination of patient care. I understand that, by signing this form, I am requesting that protected health information (PHI) regarding my care and treatment from Carissa C. Uschold-Klepfer, LCSW-R be released to another person/agency. The disclosure will go to the person/agency identified above. I understand that my information may be released to people/agencies who have different privacy laws than mental health providers. Once released, Carissa C. Uschold-Klepfer, LCSW-R cannot guarantee the information will be protected by the other party. Nonetheless, recipients of this information are prohibited, by New York State law, from re-disclosing PHI as it relates to your mental health treatment, drug & alcohol treatment, and/or HIV/AIDS status to other people/agencies. Requests for information that are made by third-parties should be redirected to the original source. I understand that signing this form is completely voluntary. Unless otherwise specified, the document with automatically expire one year after it is signed. I understand that I have the right to withdraw my consent at any time (to the extent that information has not already been released). In order to withdraw your consent, I must communicate this to Carissa C. Uschold-Klepfer, LCSW-R verbally or in writing.

_____

Signature of Client/Legal Representative Date

_____

Witness Date

SIGN HERE IF YOU DO NOT WANT YOUR PCP NOTIFIED OF YOUR TREATMENT:

SIGN: _____ DATE: _____

PLEASE COMPLETE

It is our hope to provide the highest quality of service. Below you will find a patient information sheet which provides our office with useful information that is helpful to our staff in contacting you, processing your billing and notifying you in case of an office closing, etc.

PATIENT INFORMATION SHEET

Patient Name _____ Maiden Name _____ Marital Status:_____

Date of Birth _____ SS# _____

Parent/Guardian _____

Complete Address _____

City _____ State _____ Zip Code _____ Length of time there _____

Home phone # _____ Cell Phone# _____

Employer _____Work Phone #_____Extension _____

Closest Relative (Not Spouse) _____ Relationship _____

Telephone _____

Name of Church/Affiliation _____Referral Source _____

Spouse/Legal Guardian Name _____

Address (if different from above) _____

Date of Birth _____ SS# _____ Telephone _____

Employer _____ Job Title _____

Work Telephone _____ Extension _____ Length of time there _____

MEDICAL INFORMATION

Primary Care Physician Name _____

Physician's Address _____

Insurance Carrier _____ ID# _____ Group _____

Policy Holder Name _____ Policy Holder's Date of Birth: _____

Address (if different from above) _____

*A 24-hour cancellation notification is required. There will be a late cancellation fee charged for appointments cancelled without at least a 24 business hour notice. This fee is NOT billable to any insurance carrier.

**PLEASE NOTE: You will be held liable for any collection costs and/or attorney fees in the event those services are needed to collect this debt.

***By signing this form, you are indicating that you have read and understand the accompanying office policies.

Signature _____ Date _____

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Carissa C. Uschold-Klepfer, LCSW-R

Missed Appointment Policy

When an appointment is made, an hour or more of time will be reserved for you. This time is valuable to the clinician, the staff, and other clients who need to be seen. In the event that you are unable to attend an appointment, my practice requires a **"24 business hour" (one full business day). Weekends and holidays are NOT considered business days.** If you do not provide the 24 business hour notice for cancellations, or you "no show" (miss an appointment without any notice), then a fee will be issued. These fees are not intended as punishment; but rather reflect our belief that the patient should share in the cost of the reserved room and therapist time that cannot otherwise be utilized.

Cancellations must be done by phone or in person during normal business hours, as receipt of other forms of communication (i.e. messages left with the answering service) may be delays. Please be aware that showing up more than 15 minutes late for an appointment may be considered a "missed appointment".

The policy applies even if there is good reason to miss an appointment, such as an illness or personal emergency. Nonetheless, under certain circumstances, the fee may be waived:

1. If the office is able to fill the appointment slot with another person or
2. There is a weather-related emergency, a travel ban has been issued, and you call as soon as you become aware that you cannot make it to your appointment.

It is the practice of this office to offer courtesy calls. These automated calls are sent out 2 days in advance of your appointment. However, there are times when, due to circumstances beyond our contr0ol, this does not happen. You are still responsible for keeping your appointments.

The fee for missed appointments is $50.00. The fee for late cancellations is $50.00. These fees are **NOT** billable to your insurance. By signing below, you acknowledge that you have read the above policy and fully understand it.

_____ _____

Patient/Parent Signature Date

_____

Print Name

Western New York Psychotherapy Services
Carissa C. Uschold-Klepfer, LCSW-R

Courtesy Calls

Western New York Psychotherapy Services has implemented an automated courtesy call system. The information being disclosed will be the clinician's name, as well as the date and time of the appointment. If you are interested in receiving a courtesy call, please fill out the information below and return this form to the receptionist. Please note that only one phone number can be listed for these calls. Therefore, if the patient is a child, we can only provide a courtesy call to one parent.

Patient's Name: _____ DOB: _____

Would you like to receive a courtesy call prior to your appointment? Yes _____ No _____

Phone number you would like us to call: ( ) _____ - _____

Are we permitted to speak with and/or leave messages with another party regarding scheduling, billing, and/or administrative (non-therapeutic) concerns? Yes _____ No _____

Name: _____

Relationship to Patient: _____

These reminders act as a courtesy, therefore it is your responsibility to make, keep and cancels appointments. If is your responsibility to notify us if your contact information should change. By signing this form, you are releasing WNY Psychotherapy and its business associates from any liability associated with leaving information regarding your appointment and/or billing status with the people/numbers listed above.

_____ _____

Patient/Parent Signature Date

_____ _____

Print Name Acct #

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BILLING POLICY

Please be aware that co-payments, co-insurances, etcetera are due at the time of your appointment. A five dollar ($5.00) billing fee will be added to your account if you do not pay at the time of service. If your insurance policy includes a deductible, you must pay your entire allowable at the time of services as well. If your insurance company notifies us that your deductible has been met, your account will be credited the appropriate amount. If we are certain that your deductible has been met at the time of service, the appropriate co-payment or co-insurance applies.

All co-payments for services provided to a child are the responsibility of the person bringing the child to the visit, even if you have a separation or divorce agreement that states otherwise. It is up to you to work out financial responsibility with the other parent/guardian.

Please note that an additional fee will be added each month that the balance remains outstanding. For example, after two months, the billing fee will be ten dollars ($10.00). Also, if co-payments and/or deductibles are not made at the time of service, this may prevent you from scheduling additional visits and/or future appointments may be cancelled.

Please be aware that if, at any time, there is a change of insurance, our billing office must be notified of the new insurance information at least 3 days prior to your next scheduled appointment. If new insurance information is received at the time of your appointment, the appointment will be considered self-pay until the insurance is verified by our billing office. Not all therapists participate with every insurance plan and some plans require pre-authorization in order for the insurance company to reimburse for services provided.

If you have any further questions, please feel free to contact your billing office at (716) 837-6705, option 4, Monday through Friday from 9am to 4pm.

_____ _____

Patient/Parent Signature Date

_____

Print Name