# ***CONSENT FOR TREATMENT AND HEALTH CARE OPERATIONS***

I, _____, hereby authorize, **Tracey E Reed, LCSW-R**
(Name of client/guardian) (Name of Clinician)

and his/her business associates to provide treatment and carry out healthcare operation 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. Allow your insurance company to review your file, including chart notes
h. Other: _____
(specify)

This consent form will be in effect for a period of no more that 3 years or when all communications with third parties for payment is 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: _____

# AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby authorize **Tracey E Reed, LCSW-R**,
(name of client/guardian) (name of clinician)
to release to and to receive from:

_____
(Primary Care Physician Name)

_____ _____
(address) (telephone number)

the following information (checked) about: _____:

***INFORMATION TO BE RELEASED***

_____ 1. Copies of chart notes.

_____ 2. Copies of entire record.

_____ 3. Summary of impressions, diagnosis, treatment, response to treatment, history, recommendations, psychological test results.

_____ 4. Copies of computer-generated test reports.

_____ 5. Other (specify) _____

***PURPOSE OF DISCLOSURE***

This authorization allows your mental health provider to send/receive the above information to/from the above-named parties _____. A thank you letter to the referring agency or individual is sent. The specific purpose(s) of this disclosure is(are):

_____ 1. To coordinate with other health/mental health providers.

_____ 2. To obtain insurance or employment or government benefits.

_____ 3. To coordinate with attorneys, judges, probation officers, etc.

_____ 4. To coordinate with employer.

_____ 5. To coordinate with school official/teacher, etc.

_____ 6. To obtain/provide history.

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 below.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CPR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. 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.

EXPIRATION DATE: _____

Signature of Client or Parent/Guardian: _____ Date: _____
(indicate relationship to client)

Signature of Facility Witness: _____ 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 _____

# Tracey E. Reed, LCSW

*Western New York Psychotherapy Services*

70 Linwood Avenue
Orchard Park, New York 14127
Telephone: (716) 675-9232
Fax: (716) 675-9217

315 Alberta Drive, Suite 211
Amherst, New York 14226
Telephone: (716) 837-6705
Fax: (716) 837-6759

## Missed Appointment Fee and Late Cancellation Fee Policy

I, _____, have read the policies given to me, which not only explain the services available to me, but also explain my responsibilities and obligations which include payment for services rendered and appropriate notice for sessions to be cancelled. I understand that a **24 business hour** notice is required to avoid a missed appointment or late cancellation fee. **(Weekends and holidays are NOT considered business days.)**

In the event that I do not give such notice only the following condition will waive the fee.

1. *If the roads are closed due to a weather emergency.*

We would like to emphasize that there are generally no exceptions to the above policy. In other words, the policy applies even if there is a good reason, such as an emergency that requires you to cancel your appointment.

It is the practice of this office to offer courtesy calls. These are done on a daily basis. However, there are times when, due to circumstances beyond our control, we do not have that opportunity. You are responsible for keeping your appointments. **Please note that any messages left with the answering service are viewed as less than 24 business hours notice. Also, when canceling a Monday appointment you must phone by the appropriate time on Friday.**

I also understand that I am responsible for this **$70.00** missed appointment fee or **$50.00** late cancellation fee and it is not billable to my insurance. I have discussed these fees with my therapist and fully understand them.

Signature: _____ Date: _____

# Western New York Psychotherapy Services

**315 Alberta Drive, Suite 211**
**Amherst, New York 14226**
**Phone: (716) 837-6705**
**Fax: (716) 837-6759**

**3065 Southwestern Boulevard, Suite 204**
**Orchard Park, New York 14127**
**Phone: (716) 675-9232**
**Fax: (716) 675-9217**

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

Patient Name: _____

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

Please indicate the phone number you would like for us to use: _____

In the near future, we also will be providing the option of receiving emails or texts instead of a phone call. Please indicate below if you want the following options:

_____ TEXT – Number to be used: _____

_____ EMAIL – Address to be used: _____

There may be times when you are unable to make/change appointments yourself and/or require another party to check billing status, etc. Please indicate below if there is another party we can talk to regarding appointments, billing issues, etc.

Name:_____

Relationship to Patient: (Spouse, Parent, Etc.) _____

Not Applicable: _____

Please be aware that, by signing this form, you are releasing WNY Psychotherapy Services from any liability associated with leaving or receiving information regarding your appointment and billing status.

Signature: _____ Date: _____

Acct # _____ (office use only)

# Western New York Psychotherapy Services

3065 Southwestern Blvd, Suite 204
Orchard Park, New York 14127
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## *Billing Policy*

Please be aware that co-payments, co-insurances, etcetera are due at the time of service. A $5 (five dollar) billing fee will be added to your account if the time of service requirement is not met. If your insurance policy includes a deductible, you must pay the entire allowable fee at the time of service as well. The above billing fee applies if this requirement is not met. 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.*

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 $10.00 (ten dollars). Also, if co-pays and/or deductibles are not made at the time of service, additional visits may not be scheduled and/or future appointments may be office 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 our billing office at (716)837-6705, option 4, Monday through Friday from 9am to 4pm.

_____ _____

(Patient/Parent Signature) (Date)

_____

(Print name)