CONSENT FOR TREATMENT AND HEALTH CARE OPERATIONS

315 Alberta Dr. Ste 211
Amherst, NY 14226
716 -837-6705

70 Linwood Ave.
Orchard Park, NY 14127
716–675-9232

CONSENT TO TREATMENT

This Contract is between_____James P. Maurino, Ph.D., for the purpose of psychotherapy services.

PATIENT RIGHTS

1. Be informed of your rights and responsibilities at the first interview.
2. Expect that any information, verbal or written, be kept confidential, including your status as a patient, the type of services you receive and the content of your discussions with your therapist. No information about you will be released without your written authorization except:
    A. In routine case consultation involving licensed professionals
    B. When an emergency exists where there may be danger to yourself or others, including child and/or spouse abuse, the inability to care for one's basic needs for food, clothing or shelter
    C. The court may subpoena counseling records
    D. It is understood that information regarding treatment and diagnosis may be provided to your insurance company.
    E. For non-payment of fees, which will result in such legal action for collection of the balance due as is necessary.
    F. If you are being seen in conjunction with your spouse and/or family members written authorization must be obtained from all adult numbers before any information will be released about the services provided.
3. Participate in the formulation of your goals for treatment and to a periodic review of your treatment plan.

PATIENT RESPONSIBILITIES

1. Arrived promptly for scheduled appointments. If you are a patient or guardian and your child is in treatment, you are responsible to make necessary arrangements for the child to come to scheduled appointments.
2. Provided notification 24 hours in advance if you are unable to make a scheduled appointment. Failure to do so will result in your being billed a late cancel fee for the session. Insurance may not be billed for a failed session.
3. The client portion (co-pay/Co-insurance) of fees is expected at times of service.
4. Clients paying on a cash basis, and not billing any insurance company are expected to pay in full at time of services unless a payment plan has been previously arranged.
5. In the cases of minors, the adult bringing the minor to treatment, on the date of service, is responsible for payment of client portion fees, even if a court order is in place. It is the responsibility of the adult bringing the minor to treatment to sort out financial responsibility with the custodial parent.
6. Pay your fees promptly at the time of service. If a third-party payer is involved, you must complete any procedures required to obtain coverage for the services. Billing for insurance coverage will be completed by this office.
7. Discuss any change in financial situation with James P. Maurino, Ph.D.. In the even you find it necessary to change Therapists and require records to be sent your account will need to pay in full.
8. Discuss any dissatisfaction with your therapist concerning services received.

I hereby agree to pay my fees for sessions at the time of service. I hereby agree to enter into treatment with James P. Maurino, Ph.D., and agree to the terms of treatment explained above.

_____ _____
Name Date

_____
Signature of Patient or Legal Guardian

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I,_____, hereby authorize, **James P. Maurino, Ph.D.,**
(Name of client/guardian)

to release to and to receive from:

_____

_____

the following information about:_____

INFORMATION TO BE RELEASED

1. _____1. Copies of chart notes.

_____ 2. Copies of entire record, i.e., chart notes, billing information, reports prepared by therapist, etc. (not necessarily including therapist's personal notes).

_____ 3. Summary of impressions, diagnosis, treatment, response to treatment, history, recommendations, psychological test results. (may include copies of reports prepared by therapist).

_____4. Copies of computer-generated test reports.

_____ 5. Other (specify) _____

PURPOSE OF DISCLOSURE

2. This authorization allows your mental health provider to send/receive the above information to/from the above-named parties. (In addition, a thank you letter to the referring agency or individual is sometimes 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.

_____ 5. To coordinate with school officials/teachers, etc.

_____ 6. To obtain/provide history.

_____ 7. Other _____

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.

EXPIRATION DATE: _____

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

Signature of 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 _____

James P. Maurino, Ph.D.

Western New York Psychotherapy Services

70 Linwood Ave.
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.)**

The fee will be waived if the appointment is cancelled with more than 24 business hour notice or if the roads are closed due to a weather emergency.

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.

I also understand that I am responsible for a **$75.00** Missed Appointment Fee or a **$50.00** Late Cancellation Fee and that these fees are not billable to my insurance. I have discussed these fees with my therapist and fully understand them.

SIGNATURE:_____DATE: _____

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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)

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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)