DR. JUDITH SILBERKLEIT CLIENT INFORMATION FORM page 1

Please have insurance card ready for copying. PLEASE FILL IN **ALL** INFORMATION on both sheets.

Date_____

First Name_____ Last Name _____

Address_____ Home Phone#_____

City_____ State_____ Zip_____

Date of Birth_____ Social Security # _____-_____-_____

Cell Phone # _____ Email Address _____

Have you been treated with another therapist as of the 1st of the year? If so how many sessions to date? _____

Please be advised that the client is responsible for contacting their insurance carrier to obtain their **mental health benefits and authorizations. Do you have an annual deductible on your insurance, if so how much, and has it been met?**

_____

Please be advised that the client is responsible for sessions not covered by insurance due to unmet deductible. Client is responsible when this provider is not on your particular insurance panel. I understand that I am responsible for knowing my insurance carrier's mental health benefits and am liable for payment for all unmet deductibles and copays. **No show/cancellations fees are due before the following appointment**.

FEE FOR NO SHOWS is $80. Signed _____

Insurance Company Name _____

ID# _____

Group Number _____

Name of person who is the carrier of the insurance_____

Your relationship to primary insurance carrier (spouse, child) _____

EMPLOYER of person who is the insured _____

Your relationship to the insured (self/spouse/child)

_____

Subscriber's (carrier of the insurance) DOB _____ - _____ - _____

SS#_____ (subscriber)

Address of the person who is insured _____

_____

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Insurance Behavioral Health phone # _____ (please see back of the card) or Provider Services phone #

_____

Authorization#: _____ Please call your insurance mental health benefits department and ask if you need to request authorization before our first appointment.

Address to mail claims to (see back of card)

_____

COPAY: $_____ Copays are to be paid at each session.

Referral Source _____

I authorize the release of any medical or other information necessary to process the claims to Dr. Silberkleit and to and to My Clients Plus Billing.

Signed _____ Date_____

Dr. Judith R. Silberkleit
Licensed Clinical Psychologist
Consent Form

Consent for Treatment, Treatment Policies, and Fees

Consent for Treatment

I, the undersigned, request that the above named therapist provide professional services to me, or my child (print and sign your name here) _____ as a patient.

Treatment Policies

Payment of Fees

Patients are responsible for payment of required fees and copays at each session. Patients are responsible for knowing their insurance benefits, for knowing the amount of their deductible, and for obtaining authorization from their insurance company for sessions if required by their insurance to do so. If a session is not covered by insurance due to an unmet deductible, or for any other reason, the patient is responsible for payment of that session to Dr. Silberkleit. **This holds true whether or not patient was aware of their deductible, copays, or overall benefits at time of visit.** Those of you who sign over payment of insurance reimbursement to Dr. Silberkleit are responsible for deductibles and co-payments at each session. Similarly HMO patients are responsible for co-payments at each session. If insurance company or HMO yearly maximum benefits are reached patients are then responsible for paying the entire fee at each session. Dr. Silberkleit cannot assure you that your claim will be paid by insurance, you must check with your insurance company prior to first visit to make sure you are covered, please be sure to read your policy carefully and check with your insurance carrier. Copays are due at time of visit and payable by cash or check.

Cancellation Policy

Patients are asked to give at least 24 hours notice for missed appointments, preferably 48 hours. If it is a Monday appointment, patients are asked to contact Dr. Silberkleit by the previous Thursday or 48 hours. Otherwise the patient will be responsible for the fee for the entire session since insurance companies and HMOs do not pay for missed visits. The patient will be billed 80, for a missed appointment which they themselves are responsible for. Repeated cancellations even with 24 hours notice are not acceptable, because it impedes the progress and positive outcomes of therapy, as well as takes away time from other clients who need to be seen.

I waive my rights for any and all litigation directed toward Silberkleit and Associates LLC for current and future psychological testing and treatment. I further consent to any and all collection services necessary for Dr. Silberkleit and Associates to collect fees owed for professional services, which will include disclosure of patient's name and address which is necessary for bill collection purposes, and if referred for collection agree to pay costs and expenses of collection and reasonable attorney's fees.

Signature _____ Date _____

Confidentiality

In general psychologists are obligated by state law and professional ethics to keep information you share confidential, unless you sign a written release form stating to whom the information can be shared and with the purpose of sharing the information. However, there are some exceptions to this general rule of confidentiality. These include when a law requires reporting of an event such as child abuse to DSS, or elder abuse to police or other authorities, abuse of persons with mental retardation to police or other authorities, if a patient appears to be seriously suicidal or poses a danger to self (suicide) or others (homicide) and the police or other medical professionals have to be called to come to your immediate aid, when insurance reimbursement or HMO reimbursement requires patient information such as diagnosis and dates of service, or if in an emergency a psychologist has to share patient information with another healthcare professional. Please feel free to ask any questions you may have concerning confidentiality issues.

If suicidal emergency arises, patients are instructed to call 911 or proceed to their local emergency room.

I have read and understood the treatment policies above and agree to abide by them. I also authorize the release of any medical or other information necessary to process health insurance claims and certify treatment with Judith Silberkleit, Psy.D., Licensed Clinical Psychologist for (patient name)_____
Signature_____ Date_____

I authorize payment of medical benefits to Judith Silberkleit, Psy.D., for health insurance claims for treatment of (patient name)_____
Signature_____ Date_____
Address_____

I _____ have read the above consent form, treatment policies, and fees document and am satisfied that I understand the form and agree to comply with all of the above. This consent does not expire unless I formally retract my consent.

Signature _____ Date _____

SERVICES AGREEMENT/HIPAA REGULATIONS

This agreement contains important information about my professional services and business policies. It also contains a summary of information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your protected health information (PHI) used for the purpose of treatment, payment, and healthcare operations. HIPAA requires that I provide you with a Notice of Privacy Practices (The Notice) for use and disclosure of PHI. The Notice which will be given to you if you request a copy of your own explains HIPAA and its application to your personal health information in greater detail.

I ask you to read and then sign this document. It gives your consent to receive evaluation and treatment services from me and further allows me to use your PHI as described below. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations to me you have incurred.

Limits on Confidentiality

The law protects the privacy of all communications between a patient and a mental health professional. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written advanced consent. Your signature on this agreement provides consent for these activities, as follows: your mental health professional may occasionally find it helpful to consult other mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patients. The other professionals are also legally bound to keep the information confidential. If you do not object, you will not be told about these consultations, unless it is important to our work together. We will note all consultations in your clinical record (which is called PHI in the notice of policies and practice to protect the privacy of your health information). You should be aware that this practice includes hired administrative staff, in most cases I need to share protected information for both clinical and administrative purposes such as scheduling, billing, and quality assurance. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without my permission. Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement. There are some situations where I am permitted or required to disclose information without either your consent or authorization. These are described in full in section 3 of the notice. In addition, if you are delinquent in payment after 90 days, your name and address will be given to a third party collections agency in order to obtain payment. Identifying information used to process claims with your insurance company is handled and processed by My Clients Plus and Dr. Silberkleit, who submits claims to insurance both electronically and by mail.

Professional Records

The laws and standards of the profession require that we keep PHI about you in your clinical record. Except in unusual circumstances that involve danger to yourself and others, or where information has been confidentially supplied to me by others, you may examine or receive a copy of your clinical record if you request it in writing. Because these are professional records and can be misinterpreted by untrained readers, I require that you review that in my presence or another mental health professional so you can discuss the contents. If I refuse your request for access to your records, you have a right of review which can be discussed with you upon request. Some clinicians also keep a set of psychotherapy notes, which are for are for our own use and not part of the clinical record. These psychotherapy notes are not available to you and cannot be sent to anyone else, including insurance companies, without your written signed authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

Patient Rights

HIPAA provides you with several new or expanded rights with regard to your clinical record and disclosure of PHI. These rights include requesting that we amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting and accounting of most disclosures of PHI that you have neither consented to nor authorized; determining the location to which PHI disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this agreement, notice form, and my privacy policies and procedures.

Minors and Parents

Patients under 16 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records unless we decide that such access is likely to injure the child. (There are circumstances in which we can provide treatment for not more than 6 sessions to a child under 16 without parental consent or notification, but the requirements for such nonconsensual treatment are complicated and can be discussed upon request.) Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request from parents that they consent to give up access to their child's records. If they agree, during treatment we will provide them only with general information about the progress of the child's treatment and attendance of scheduled sessions. We will also provide parents with a summary of the child's treatment when it is complete. Any other communication will require the child's consent, unless the child is in danger or is a danger to someone else, in which case, the parents will be notified.

Billing and Payments

You will be expected to pay for each session at the time it is held unless we agree otherwise or unless you have health insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed on, we have the option of using legal

means to secure payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most situations, the only information released regarding a patient's treatment is name, the nature of the services provided, and the amount due.

Insurance Reimbursement

If you have a health insurance policy it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however you (not your insurance company) are responsible for the full payment of our fees. We expect that whatever copay that is due will be paid each session. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage call your plan administrator. You should also be aware that your contract with your health insurance company requires we provide with information relevant to the services that we provide you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical records. In such situations we will make every effort to release only minimum information about you that is necessary for the purpose requested.

We will charge for missed appointments or cancellations that are made with less than 24 hours notice. We also reserve the right to telephone contacts of 10 minutes duration or less; insurance carriers do not reimburse for these charges.

Your signature below indicates that you have read this agreement and agree to its terms and also serves as an acknowledgement that you have been offered the HIPAA notice form described above.

Name (Print): _____

Signature: _____

Date: _____

CLIENT COPY – PLEASE READ AND KEEP

DR. JUDY SILBERKLEIT

CLINICAL PSYCHOLOGIST

drjudys@hotmail.com

203 386 8188

ATTENDANCE AND COMMITMENT TO THERAPY

Therapy sessions are 45 to 50 minutes long, and are generally scheduled on a once a week basis. Regular attendance helps to build momentum for positive change. Sometimes due to scheduling issues, clients will choose to attend every two weeks, once per week is preferable for optimal treatment. The most progress is made when people maintain consistent attendance in therapy. A crucial part of counseling involves committing yourself to doing the work necessary to bring about the goals you want to achieve. Without commitment to therapy and consistent attendance, your progress may be less than what you would like.

There is a 24 hour minimum cancellation policy. If this policy is not followed you will incur an 80. fee which is not covered by insurance. However, repeated cancellations even with 24 hours notice are not acceptable, because it impedes the progress and positive outcomes of therapy, as well as takes away time from other clients who need to be seen.

Thank you for your understanding and cooperation!