

Group #: _____ Address to send claims: _____

Phone #: _____

F. Were you given an Authorization number YES NO Number _____

G. Do you consent to authorize discussion with your insurance company YES NO

What is the name of the Company issuing the authorization service _____

H. Have you been in counseling before, if so with whom? _____

I. Primary Care Physician name: _____

Address: _____

Telephone #: _____

Are you presently taking any medications? If yes, what and with whom _____

J. Please circle areas that pertain to you:

- | | | | |
|-------------------|----------------------------|------------------|---------------------|
| Nervousness | Depression | Fears | Shyness |
| Divorce | Sexual Problems | Separation | Finances |
| Suicidal thoughts | Drug Use | Alcohol problems | Friends |
| Anger | Self-control | Hearing voices | Sleep |
| Stress | Work | Relaxation | Headaches |
| Violent thoughts | Memory | Ambition | Legal matters |
| Energy | Insomnia/Sleeping problems | Making Decisions | Loneliness |
| Concentration | Inferiority | Education | Marriage |
| Health Problems | Temper | Nightmares | Career choices |
| Children | Appetite | Bowel trouble | Parenting |
| Thoughts | Unhappiness | Tiredness | Physical complaints |
| Stealing/Lying | Running away | Clumsiness | Over Sensitive |
| Eating problems | Nervousness | School Problems | Over activity |
| Under activity | Self Critical | Temper Tantrums | Easily upset |
| Toilet problems | Unusual habits | Aggression | Jealousy |
| Over dependency | Cruelty | Overly guilty | Destructiveness |

K. I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to Ira L. Bilofsky, PA-Licensed Clinical Social Worker Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

Client's (or parent/guardian's) signature

Date

L. I authorize the use of this form on all my insurance submissions. I further authorize release of information to all my insurance carriers and/or managed care companies. I authorize Ira L. Bilofsky, PA-Licensed Clinical Social Worker to act as my agent in helping me obtain payment from my insurance carrier. I understand that I am financially responsible for all non-covered services or unpaid balances. I authorize payment directly to Ira L. Bilofsky, PA-Licensed Clinical Social Worker, I permit a copy of this Authorization to be used in place of the original.

Clients (or parent's/legal guardian) signature

Date

M. I acknowledge that I have been informed of this Psychotherapists cancellation rules and further acknowledge that **I am required to give 24 hours notice on all cancellations.** Please remember that my time is valuable and that when you do not cancel that others cannot be brought in. All cancellations outside this period will be charged the full fee of \$122.00 as this incident is not chargeable to your Insurance Company. Exceptions made for emergencies. There is also a \$50 charge per occurrence for all returned checks.

Clients (or parent/legal guardian) signature

Date

Authorization to Disclose Protected Health Information

Communication between behavioral health providers and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow us to share protected health information (PHI) with your primary care physician (PCP), Insurance Behavioral Healthcare Vendor, and other providers (such as psychiatrist or other specialists) and schools.

I, _____ / / _____ authorize
Member Name Security Number Date of birth

Ira L. Bilofsky, License, # CW-006995-L, to release protected information related to my evaluation and treatment: (Please Check the people who release pertains to).







- Behavioral Healthcare Provider: _____
Address/Phone #: _____
- Primary Care Physician: _____
Address/Phone #: _____
- School and/or other Providers: _____
Address/Phone #: _____

TO EXCHANGE THE FOLLOWING INFORMATION in order to coordinate treatment: (Medical, Behavioral Health (including Alcohol and Substance Abuse) and Work and School)

- Diagnostic Information
- Psychological Testing
- Medication Management
- Brief Clinical if necessary: _____

- Specify other: _____

Patient Rights

-  You may terminate this authorization at any time. Your request must be in writing and forwarded to Ira L. Bilofsky, 1019 Winfield Ct., Lansdale, PA 19446.
-  If you make a request to terminate your authorization, it will not include information that has already been sent.
-  You cannot be required to sign this form as a condition of treatment, payment, or eligibility of benefits.
-  Information that is disclosed as a result of this authorization may be re-disclosed by the recipient and no longer protected by law.
-  You have the right to a copy of this form. Please keep for your records.
-  You do not have to agree to this request.

Patient Authorization

I, the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified. I have read and understand the above information and give my authorization:

- To release any applicable records to the providers listed above.
- Release to Ira L. Bilofsky, 1019 Winfield Ct., Lansdale, PA 19446 (610) 831-8810.
- To release information related to medication only.
- I DO NOT give my consent to release any information.

Patient signature Date Signature of Authorized Representative Date

If signed by Authorized Representative, describe relationship to patient: _____

I have discussed this document in full with this patient and/or authorized representative and witnessed their signature.

Ira L. Bilofsky, LCSW, BCD Date

Copy given to Patient and/or Authorized Representative

NOTICE TO INTENDED RECIPIENT OF INFORMATION:

This information has been disclosed to you from records the confidentiality of which is protected by Federal and/or State law. If the records are protected under the Federal regulations on confidentiality of alcohol and drug abuse patient records (42 CFR part 2) you are prohibited from making further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical records or other information contained is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute and alcohol or drug abuse patient.

NOTICE OF PRIVACY PRACTICES / STATEMENT OF UNDERSTANDING

Effective Date: April 14, 2003

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

- 1) **CONSENT TO TREATMENT:** I acknowledge that I have received, have read (or have had read to me), and understand the information about the Psychotherapy I am considering. I have had all of my questions answered fully. I do hereby seek and consent to take part in this treatment with Ira L. Bilofsky. I understand that developing a treatment plan with the therapist and regularly reviewing or work toward meeting the treatment objectives are in my best interest.
 - I agree to play an active role in the process and on on-going treatment.
 - I understand that no promises have been made to me as to the result of treatment or any procedures provided by this Psychotherapist.
 - I am aware that I may stop treatment with this psychotherapist at anytime. The only thing I will still be responsible for is paying for the services already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment.
 - I know that the office policy for cancellation is 24 hours ahead of a scheduled appointment. Failure to cancel and or not show up for an appointment is subject to a charge of \$122.00.

- 2) **CONFIDENTIALITY:** Federal and State Law and regulations protect the confidentiality of your records. The principal purpose of maintaining information about you is to document your assessment, intervention and follow up activities. The highest professional standards will be adhered to in the maintenance of your record. Two Federal laws that protect your health information are the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and the confidentiality law 42 C.F.R. part 2. Under these Laws I may inform others that attend this program or disclose any of your protected information except as permitted by Federal Law and/or you.

- 3) **DISCLOSURE OF INFORMATION**
 - When the client consents in writing. Any such written consent may be revoked by you in writing.
 - Pursuant to an agreement with a qualified service or Healthcare operation/business associate.
 - We may use your information to assist in treatment services. Treatment means the provision, coordination or management of care.
 - We may release your information so that your treatment and services may be billed and payment collected from an insurance company or third party.
 - Information relating to the treatment of minors will be kept private according to Federal and State laws. Information will be released when there is suspected child abuse or elder care abuse. Many States allow minors, after a certain age, to receive services without permission from their Parent's. I follow all applicable laws that apply to treatment of minors. In cases, where divorce brings a child into treatment, permission must be sought for by both parents.
 - I will release information when required or permitted to do so by Law for Public Safety. Disclosures maybe made to protect you from serious threat to your health or the health and safety and/or to protect the health and safety of another person. Disclosures may also be made when requested by Federal officials for National Security or Intelligence activities or for the protection of public figures. Your information may also be released when required by Law for Government Security Clearances.
 - Your information will be released for the purposes of audit or evaluation.
 - Other uses and disclosures made by your consent. You are permitted to discontinue such permission at any time in writing. Requests to discontinue will be honored except when the information has already been forwarded based on a previous request to disclose.

- 4) **YOUR RIGHTS:** Under HIPPA you have the right to request restrictions on certain uses and disclosures of your protected Health Information (PHI). I am not required to agree to any restrictions you request, but if I do agree I am bound by the agreement and may not disclose information you have restricted.
 - You have the right to request that I communicate with you by alternate means or at an alternate location. While I am not required to agree I will accommodate any request that is reasonable.
 - You have the right to inspect and copy your PHI maintained in your record, with the exception of psychotherapy notes. These are protected by HIPPA of 1996. Other information requested for the use of Civil, Criminal or other Administrative proceedings must be made in writing. Each request will be accommodated as quickly as possible but may take up to thirty days for completion.
 - You have the right with some exceptions to amend PHI maintained in your record and to request an accounting of the disclosure of your PHI.
 - You have the right to receive a copy of this notice.

1. You have the right to decide not to enter therapy with this Psychotherapist. If you wish I will provide you alternate names of other providers.
 2. You have the right to end treatment at any time. You will remain responsible for unpaid co-payments, and Insurance non-payments and/or cancellations.
 3. You have the right to ask any questions, at any time, with reference to what we are doing in treatment and receive answers that satisfy you. If you do not understand I will explain all usual treatment methods.
 4. You have the right to keep what is told during therapy confidential. Generally, no one will learn or our work without your written consent. There are some situations in which your protected information has to be disclosed. These reasons involve:
 - A serious threat to harm another person, I am required to warn that person and the authorities.
 - If a Court, specifically a Judge, orders testimony and/or release of information about you, I must do so.
 - If you are suspected of or involved in Child Abuse.
 - Your Insurance Company requires that I inform them of session dates and documentation for continued treatment.
- 5) **COMPLAINTS:** If you believe I have violated your privacy as described in the above notice you have the right to file a complaint in writing. This complaint should be filed with my compliance officer, Carolyn Bilofsky, 1019 Winfield Court, Lansdale, PA 19446 or with the Secretary of Health and Human Services at 200 Independence Ave., S.W., Washington, DC 20201.
- 6) **MY SIGNATURE** below means I have read this document, understand it, have been given the opportunity to ask questions for clarification and have received a copy for my records.

Print Client Name

Signature of Client or Guardian

Date

Witness

Date

I, Ira L. Bilofsky, have discussed the issues with the client or their Guardian. My observations of this person's behavior and responses give me know reason to believe that this person is not fully competent to understand and give consent.

Ira L. Bilofsky
PA-Licensed Clinical Social Worker
Board Certified Clinical Social Worker

Date

Statement of Patient's Rights

- # Be treated with dignity and respect.
- # Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability or source of payment.
- # Have their treatment and other member information kept private. Only where permitted by Law, may records be released without patient permission.
- # Easily access timely care.
- # Know about treatment choices. This is regardless of cost or coverage through the patient's benefit plan.
- # Share in developing the treatment plan.
- # Information in a language they can understand.
- # A clear explanation of their condition and treatment options.
- # Information about clinical guidelines used in providing and managing their care.
- # Ask provider about their work history and training.
- # Give input on the patient's Rights and Responsibilities policy.
- # Know about advocacy and community groups and prevention services.
- # Freely file a complaint or appeal and to learn how to do so.
- # Know of their rights and responsibilities in the treatment process
- # Receive services that will not jeopardize their employment.
- # Request certain preferences in a provider.
- # Have provider decisions about their care to without regard to financial incentives.

State of Patient Responsibilities

- # Treat those giving care with dignity and respect.
- # Give providers the information that they need. To enable a quality level of care.
- # Follow the treatment plan. The treatment plan is to be agreed upon by all parties.
- # Follow the agreed to medication plan.
- # Tell your provider and primary care physician about medication changes, including medications by other Physicians.
- # Keep your appointments. Patients should call the provider as soon as they know they have to cancel.
- # Let the provider know if the treatment plan isn't working.
- # Let provider know if you are having problems making payments. Arrangements can be made.
- # Report fraud and abuse.
- # Openly report concerns about the quality of care you receive.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

Patient or Guardian Signature Date

The signature below shows that I have explained this statement to my patient. I have offered a copy of this form.

Ira L. Bilofsky Date
PA-Licensed Clinical Social Worker
Board Certified Clinical Social Worker