Robin Friedman, LCSW www.RobinFriedmanLCSW.com

914-505-7855, ext. 3. (office) Robin@RobinFriedmanLCSW.com

Outpatient Informed Consent and HIPPA Agreement

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and note any questions you may have so that you and I can discuss them at our next meeting. When you sign this document, it forms a contract that guides our working together.

Psychotherapy and Counseling Services

Psychological treatment varies depending on a number of factors. These include the specific needs, issues, history and personality of the client, as well as the training and personality of the therapist. While there are many methods I may use to address the issues you present, psychotherapy requires an active effort on your part. Together we can work to address the issues and challenges you are experiencing.

Psychotherapy can have both benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, or helplessness. On the other hand, psychotherapy has been shown to have significant benefits for people who go through it. Therapy often leads to better relationships, solutions to problems, and significant reduction in feelings of distress. However, there are no guarantees about what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of this period, I will be able to offer you some initial impressions of what our work will include and goals we could work toward. You should evaluate this information along with your own assessment about whether you feel comfortable working with me. Psychotherapy involves a significant commitment of time, money and energy, so you should be careful about the therapist you select. If you decide to discontinue your work with me, I can help you secure an appropriate consultation with another mental health provider. Please feel free to express any questions or concerns as they arise.

Communication

In between sessions, if there is something that you need to discuss with me that is related to your treatment or is clinical in nature, you may contact me to inquire about setting up an additional appointment. Additional appointments may be in office sessions, video sessions, or phone sessions. An additional appointment cannot be guaranteed and will depend upon my work availability.

To communicate with me about the logistical aspects of our work — such as changing an appointment time, letting me know that you are running late to session, or to request an additional appointment, you can contact me via e-mail at robin@robinfriedmanLCSW.com or via text at 914-363-0055. If you contact me between the hours of 9 AM Monday and 5 PM Thursday, my response to your communication may take up to 24 hours. If you contact me after 5 PM on Thursday, or on a national holiday, I will respond to you by 5 PM of the next business day, if not sooner. Please keep in mind that no electronic communication is guaranteed to be private. I recommend using email and phone ONLY to discuss non-clinical aspects of our work, such as scheduling related issues.

Additionally, these forms of communication should not be used for emergencies. If you are in crisis or a life-threatening emergency, call 911 or go to the nearest emergency room and request to speak with a mental health professional.

Additionally, if I will be unavailable for an extended period of time, I will indicate the length of my absence and inform you in advance.

Meetings and Cancellations

If you and I decide to work together, we will usually schedule one 45 -minute session per week at a mutually agreed-upon time. If you need to cancel an appointment, you will be responsible for informing me at least 24 hours in advance on weekdays and 72 hours in advance for weekend or Monday appointments to avoid a Missed Session Fee equal to that of my full session fee. Health plans do not cover payment for missed appointments, thus you will be responsible for the Missed Session Fee.

Professional Fees, Insurance Billing, and Payments

Initial intake and ongoing therapy sessions are 45 minutes in duration and are billed at the standard fee available or at the contracted insurance rate.

As a Licensed Clinical Social Worker, I am recognized as a reimbursable Mental Healthcare Provider whose services are accepted by most insurance companies. I have worked with Cigna, Aetna, Blue Cross/Blue Shield, United Healthcare, as well as many other plans. My office works closely with insurance specialists, who will check your benefits, copayment, deductibles and co-insurance, and will submit ALL insurance claims on your behalf.

You will be responsible for copayments, co-insurance, or your deductible as outlined by your particular plan. If your insurance fails to authorize units of service, or if no units of service are available to you, you will be held responsible for the full session fee.

Session fees, copays, or co-insurances are payable at the time of service by check, or by using Zelle - a person to person payment service, unless another arrangement has been made.

Zelle is used by many major U.S. banks including Chase, Bank of America, Citibank, Capital One, Commerce Bank, Wells Fargo and US Bank, as well as many others. If your bank does not use Zelle, you can still sign up at Zellepay.com or download the Zellepay app and use a debit card. When making a payment via Zelle, please use Robin@RobinFriedmanLCSW.com as the recipient's email and please enter the Date of Service in the memo space provided. **You will be responsible for making the session payment at the time of service.**

A credit card will be to be kept on file to be used ONLY to collect Missed Session Fees. Should a balance accrue and no payment is received, I reserve the right to seek renumeration, by legal means, including but not limited to, the retention of a collection agency.

Confidentiality

In general the law protects the privacy of all communications between a client and a mental health clinician and I can only release information about our work with your written consent. Those instances and a few exceptions are listed below:

•INSURANCE COMPANIES AND THIRD PARTY PAYERS. If you use insurance, the insurance company may require me to provide some information about your treatment. By signing this agreement, you allow me to release information necessary for this purpose. Additionally, by

signing this agreement and wherein a third party payer other than insurance has been identified by you, I am allowed to charge this party directly for services you have received.

•ADMINISTRATIVE STAFF. You should be aware that I employ administrative staff. In most cases, I need to share protected information with these individuals for administrative purposes, such as scheduling, billing, and quality assurance. All staff members and contractors have ben given training about protecting your privacy and have agreed to not release any information outside of the practice without my written consent.

•LEGAL PROCEEDINGS. In most legal proceedings you have the right to prevent me from providing any information about your treatment. However, in some cases involving child custody and those in which your emotional condition is an important issue, a judge may order me to testify.

•CONSULTATION. Sometimes I find it helpful to discuss your treatment plan with another professional; however I do not disclose your name or identifying information. Additionally, any professional with whom I confer is also ethically bound to maintain client confidentiality. With your signature, you allow me to confer as needed with other professionals in my field of practice in the best interests of your treatment and with the discretion noted above.

•FAMILIES, COUPLES and GROUPS. When I work with more than one person at a time, it is impossible for me to insure that information that is shared remains confidential. Out of respect for each other and the treatment, it is important that members of the family, couple, or group agree to maintain each other's confidentiality. However, this is a voluntary agreement and is not binding by law. Additionally, if one of you tells me something that you do not want the other to know, I cannot maintain that confidentiality if doing so is detrimental to the treatment.

•CHILDREN AND TEENS. For clients under the age of 18, please be aware that the law may provide your parents with the right to examine your treatment records. When possible, I will disclose the matter with you before I disclose any records to your parents and do my best to respond to any concerns you may have. I will encourage you to share information with your parents. I will periodically meet with your parent(s) to give them a general sense of what we have worked on.

•POTENTIAL HARM TO SELF OR OTHERS. If a client is demonstrating a genuine threat of inflicting serious bodily harm to another, I must take protective action such as notifying the potential victim, contacting the police, or seeking hospitalization for the client. If a client threatens to harm him or herself, I may alert appropriate individuals such as family members or emergency contacts who can provide protection and supervision of the client and/or recommend hospitalization of the client if the client presents a physical danger to self.

As a result of passage of NY State's Safe Act, I am now mandated to report to the authorities patients who are at imminent risk of harming themselves or others for the purpose of those authorities checking to see whether such patients are owners of firearms, and if they are, or apply to be, then limiting and possibly removing their ability to possess them.

•ABUSE OR NEGLECT. I am required by law to report suspected abuse or neglect of a child, elderly person, or disabled person.

Client Records

The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your clinical record. Except in unusual circumstances that involve danger to yourself and others or makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your clinical record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or confusing to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents.

In most situations, I am allowed to charge a copying fee of $.50 cents per page (and for certain other expenses like postage). If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others) which I will discuss with you upon request.

NOTICE OF PRIVACY PRACTICE

The Department of Health and Human Services has established a “privacy rule” to help ensure that personal healthcare information (PHI) is protected for privacy. The Privacy Rule provides standards for healthcare providers to follow when disclosing health information that is needed to carry out treatment or obtain payment.

The privacy of your personal medical or mental health records will be respected and all will be done to secure and protect that privacy. Information will be disclosed only to those in need of your health care information. The minimum amount of information necessary will be released. I will provide care that it is in your best interest.

You have the right to request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize the release of PHI to any party that is not directly connected to your treatment or payment.

Your Satisfaction is Important

I hope that you will be happy with what is happening in therapy! However, if you are ever dissatisfied with your sessions, or have questions, then I hopes you will speak with me so I can respond to your concerns. Your thoughts will be taken seriously and treated with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time.

You have the right to:

● Considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment.
● Ask questions about any aspect of the therapy and about my specific training and experience.

Outpatient Informed Consent and HIPPA Agreement

Your signature indicates that you have read this Consent and agree to its terms. It also serves as an acknowledgment that you have received the HIPAA Notice Form described above and that you consent to treatment.

_____
Client Name (Printed)

_____ _____
Client Signature Date

_____
Parent/Legal Guardian Name (Printed) - if applicable

_____ _____
Parent/Legal Guardian Signature - if applicable Date

Client Information Form

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: _____ May we leave a message? _____Yes ____No

Cell/Other Phone: _____ May we leave a message? _____Yes ____No

E-mail: _____May we email you? ____Yes ____No
(Please note: Email correspondence is not considered to be a confidential medium of communication).

Marital Status:

___ Never Married ___ Domestic Partnership ___ Married

___ Separated ___ Divorced ___ Widowed

Please list any children (name/age):

_____

Occupation: _____ Employer_____

Person to contact in the event of an emergency:

_____Relationship to you:_____

Phone Number:_____Address: _____

How did you hear or learn about our services? _____

_____

If it is a person, may we have your permission to thank this person for the referral? _____

INSURANCE CARD INFORMATION

Name of Primary Insurance:_____

Insurance ID: _____

Group No. _____

Subscriber's name: _____

Date of Birth: _____

Name of secondary insurance (if applicable): _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Robin Friedman, LCSW. or the insurance company to release any information required to process my claims.

Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF BILLING INFORMATION

The information covered by this authorization includes ONLY billing information pertaining to your treatment with Robin Friedman LCSW. This information, including service types, dates and times of services, and diagnostic codes, may be shared with the parent/guardian responsible for your billing. Please list the names and phone numbers of any parent, guardian, or other individual that you wish to have authorization to receive billing information on your behalf, correspond with our staff regarding billing information on your behalf, and to make payments on your behalf.

_____

_____

This authorization is effective through life unless revoked or terminated by the patient or the patient's representative. You may revoke or terminate this authorization by submitting a written revocation to Robin Friedman LCSW.

The Name of the Patient: _____

Signature: _____ Date: _____

CREDIT CARD AUTHORIZATION

I, _____authorize Robin Friedman LCSW. to keep this card on file and to use this card **ONLY** for the purpose of charging outstanding balances which include either missed session fees and/or session fees not covered by insurance. I understand that I will be informed by Robin Friedman, LCSW. or a member of her office prior to this card being used for such purpose. I understand that I am responsible for paying for sessions at the time of service and by using payment methods as outlined in the Informed Consent agreement.

If my insurance company issues checks to me for visits with Robin Friedman LCSW, I will sign them over to Robin Friedman LCSW, and bring them to my session within 2 weeks from the date of issue, or my credit card on file may be charged for the amount of the check.

If I need to cancel an appointment, I will provide 24 hour notice (72 hours for weekend or Monday appointments) or Robin Friedman LCSW will charge a cancellation fee equal to that of my full session fee. I understand that insurance will not cover payments for missed visits.

This authorization will remain in effect until I notify Robin Friedman LCSW that I do not want future charges to be authorized.

Please write legibly. Please double check the numbers you've written to ensure correct information is given.

Cardholder Name:_____

Cart Type: _____

Credit Card Number:_____

Expiration Date: _____ CVV code:_____

**Signature: _____ Date: _____