E R I N G I L B E R T , M S W
226 West 26th Street, 8th floor #7, NY, NY 10001
www.egtherapy.com / eringilbertmsw@gmail.com
T. 646.580.7025

Client Information/ Child or Adolescent

NAME: _____

Address: _____

_____

Date of Birth: _____

Child's Email Address (if applicable): _____

Home Telephone: _____

Child's Mobile Telephone (if applicable): _____

Please circle preferred telephone number.

Is it ok for therapist to leave a message for your child at the child's preferred number if necessary?	Yes / No
Is it ok for therapist to text your child on the child's mobile (if applicable) if necessary?	Yes / No
Is it ok for therapist to email the child at the provided email address (if applicable) if necessary?	Yes / No

Emergency Contact Person: _____

Relationship to Client: _____

Telephone #1: _____

Telephone #2: _____

Parent or Guardian #1

NAME: _____

Address: _____

_____

Email: _____

Home Telephone: _____ **Work Telephone:** _____

Mobile Telephone: _____ **Date of Birth:** _____

Please circle preferred telephone number.

Is it ok for therapist to leave a message for you, the parent/guardian, at the preferred number if necessary?	Yes / No
Is it ok for therapist to text you, the parent/guardian, on your mobile if necessary?	Yes / No
Is it ok for therapist to email you, the parent/guardian, if necessary?	Yes / No

Parent or Guardian #2 if applicable

NAME: _____

Address: _____

_____

Email: _____

Home Telephone: _____ **Work Telephone:** _____

Mobile Telephone: _____ **Date of Birth:** _____

Please circle preferred telephone number.

Is it ok for therapist to leave a message for you, the parent/guardian, at the preferred number if necessary?	Yes / No
Is it ok for therapist to text you, the parent/guardian, on your mobile if necessary?	Yes / No
Is it ok for therapist to email you, the parent/guardian, if necessary?	Yes / No

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Permission to Treat a Minor

I hereby authorize Erin Gilbert to provide clinical services to my child

_____.

Signature of Parent or Guardian: _____

Printed Name of Parent or Guardian: _____

Date: _____

Signature of Parent or Guardian: _____

Printed Name of Parent or Guardian: _____

Date: _____

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Acknowledgement of Receipt of Service Agreement

I have read the Service Agreement and consent for myself or my child to receive psychotherapy services under the terms outlined.

Signature of Client or Representative: _____

Printed Name of Client or Representative: _____

If Not Client, Relationship to Client: _____

Date: _____

Copy given to client or his or her representative: YES / NO

Acknowledgement of Receipt of Notice of Privacy Practices

This form is acknowledgement that you (the client or the client's personal representative),

_____ have received a copy of the Notice of Privacy Practices (NPP).

When I use the term "you" below, it will mean the client (or your child, relative or other person if you have written his or her name above).

By signing this form, you are acknowledging that I have provided you with a copy of the NPP. The NPP explains in more detail your rights and how I can share and use your information.

In the future, I may change how I use and share your information and so may change my NPP. If I change it, you are able to request a copy.

Signature of Client or Representative: _____

Printed Name of Client or Representative: _____

If Not Client, Relationship to Client: _____

Date: _____

Copy given to client or his or her representative: YES / NO

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Agreement for Services

PROFESSIONAL FEES: My fee for a 45 minute psychotherapy, evaluation, or consultation session will be agreed upon in advance of or during our first session, with an exception for those who are accessing in-network mental health benefits from medical insurance. In this case, only appropriate deductible/ co-pay/ co-insurance amounts will be collected.

Following our initial consultation, an invoice will be provided to you monthly with the expectation that you will promptly pay this monthly fee. Additional fees may be charged for professional time outside of the therapy hour (e.g., telephone consultations beyond 15 minutes), which will be pro-rated according to your usual hourly fee for services. Credit card payments are not accepted at this time.

USING YOUR INSURANCE: I currently am a participating provider on BCBS's and Magnacare's insurance panels, and am considered out of network on all other plans. However, I will do my best to provide insight into how to access out-of-network insurance coverage.

CONFIDENTIALITY: The psychotherapy services I provide constitute confidential and privileged communication. Information regarding these services is kept in a secure location. Information stored or transmitted electronically is password-protected and secure to the extent that current technology permits, though please note that as email, video, cell phone and cordless phone communications can be accessed by unauthorized people, the privacy and confidentiality of such communication can be compromised. Please alert me if you would like to avoid or limit in any way the use of any or all of the above-mentioned communication devices.

Information about treatment may only be released with patient/responsible adult written authorization, unless otherwise mandated by law, namely, suspected child, elder, or spousal abuse, dangerousness to others or self, certain legal proceedings, and conditions of the Patriot Act. Information also may be released should assistance be required to collect payment when such payment is past due. The confidentiality of information released to another person or agency (for example, to another therapist or to an insurance company) cannot be guaranteed; I cannot be held liable if the other person or agency re-releases the information without your authorization. You will receive a copy of my Healthcare Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices.

EMERGENCY PROCEDURES: I am not in this office every day and therefore cannot respond immediately to crisis situations. If you think you are having a mental or physical health emergency, you need to call 911 and/or go to the emergency room of the nearest hospital. If you need to contact me between sessions, please call me and follow the recorded instructions. If you do not receive a return call within 24 hours, assume mechanical failure of the voice mail system and call again. Do not use email to contact me for an emergency.

CANCELLATION: Please call to reschedule or cancel at least 24 hours in advance of your scheduled appointment time or the full fee will be charged for missed sessions without such notification. If you use email to cancel your appointment, please also call me as well so that I can be certain that I have received your message. For all patients, if you do not show up for a scheduled session and provide no notice, your reserved time slot may be made available for other patients. If you do not show for two scheduled sessions and provide no notice, I will assume you would like to end treatment and I will send you a letter or an email alerting you of the closure. Frequent no-shows may result in termination from treatment and notice will be provided to you in advance of such an action.

COMPLAINTS AND CONCERNS: You are encouraged to discuss concerns about any aspect of our work together with me at any time.

ENDING PSYCHOTHERAPY: If I determine that I am unable to help you reach your therapeutic goals either during the first few meetings or at any point during therapy, I will give you a referral. If you request it and authorize it in writing, I will talk to the psychotherapist of your choice in order to help with the transition. You have the right to terminate therapy at any time.

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT ME.

I am committed to keeping your personal health information private and secure. I protect your personal health information by maintaining safeguards that meet or exceed applicable state law and the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). If you are a parent or guardian of a dependent under my care, this notice applies to your dependent's health records and references to "You" in this notice refer to you in your capacity as parent or guardian. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change my practices and the terms of this Notice at any time, and to make the new notice effective for all protected health information that I maintain. Upon request, I will provide you with any revised Notice of Privacy Practices.

Uses and Disclosures of Personal Health Information

I will not use or disclose your health information without your authorization, except as described in this notice. When you become my patient, you will be asked to sign a consent form allowing us to provide clinical services to you, use your personal information for treatment, payment, and health care operations. For example:

- Treatment. I will use your information to create a case record, determine the best course of treatment, coordinate your care, consult with other professionals as necessary, or make referrals.
- Payment. I will use your information to determine eligibility under health plans, manage billing and claims procedures, and collect payment from you or third-party payers if applicable.
- Health care operations. I will use your information to assess the care and outcomes of treatment and to improve the quality of my services.

I may also use your personal health information where required or permitted by law. These situations include:

- Emergencies. In an emergency, I may use or disclose health information to notify a family member, personal representative, or person responsible for your care, to determine your location and condition.
- As required by law. I may notify authorities of alleged abuse or neglect; risk or threat of harm to self or others; information required for public health, law enforcement, or national security purposes; information in response to a subpoena, judicial order, or similar legal process; information required by agencies responsible for oversight or regulation of health care providers; information pertaining to my compliance with HIPAA requirements.
- Research. I may disclose your protected health information without key pieces of identifying information to researchers if an institutional review board or privacy board has approved the research protocols to ensure protection of your privacy.
- Appointment Reminders and Alternative Treatments. I may use your information to contact you about an upcoming appointment or inform you about treatment alternatives.
- Business Associates. There are some jobs that I may hire other businesses to do for me. Examples include insurance billing services, auditors and attorneys, some of whom may need to receive some of your personal health information to do their jobs properly.

In all other situations, I will use or disclose your health information only with your written authorization. If you sign an authorization, you have the right to revoke the authorization to prevent future uses and disclosures.

Your Rights as Patient

You have the following rights with respect to your protected health information:

- Restrictions. You may request restrictions on how I use or disclose your health information; your request will be considered but I am not legally obligated to agree to your requested restriction.
- Confidentiality. You may request that your health information be communicated to you in a confidential manner, such as sending mail to an address other than your home.
- Access. You may inspect and copy your protected health information or request a summary of your health information; if you request copies of your records or a summary, you may be charged reasonable fees for these services.
- Amendment. If you believe information in my records is incorrect, you may request an amendment to your health information.
- Accounting of Disclosures. You have the right to receive an accounting of disclosures of your protected health information.

My Duties

I have the following obligations with respect to your privacy and this notice:

- I am required by law to maintain the privacy of protected health information and to provide my patients with notice of my privacy practices.
- I am required to abide by the terms of this notice while it is in effect.
- I reserve the right to change the terms of this privacy notice and make the revised notice applicable to all health records maintained by my office. If I change my privacy notice, you always have the right to request an updated copy.

Complaints

If you believe your privacy rights have been violated in any way, you may file a complaint in writing with me. I will attempt to resolve your complaint promptly. You also have the right to file a complaint with the Secretary of the U.S. Department of Health and Human Services. I will not retaliate against you for filing a complaint under any circumstances.

Effective Date

This notice is effective August 28, 2008.

Questions

Any questions or concerns relating to your privacy rights should be directed to me.