# Medical Support Counseling

**Andrea Feldmar, M.A., L.M.H.C.**

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## PATIENT REGISTRATION INFORMATION

- **Patient's name:_____**

- **Date of birth: _____ Gender:_M F _____**
- **What is the patient's contact information?**

**Address:_____**

**City:_____ State :_____ Zip: _____**

**Preferred Phone:_____ Other Phone:_____**

**Work Phone:_____ [ok to call? Y N ]**

**Email:_____@_____**

- **Employer/Occupation: _____**

**_____**

**Permission to communicate by: (please circle Y or N)**
**phone message: Y N , email: Y N , text: Y N**

- **Are you a: (Patient, Caregiver, Survivor, Other)**

**_____**

- **Relationship to the patient? (spouse, child, friend, etc.)**

**_____**

- **If you are a caregiver, please enter the patient's name**

**_____**

- **Does the patient have minor children? Ages?**

**_____**

- **What is the patient's emergency contact information?**

**Address:_____**

**City:_____ ST :_____ Zip: _____**

**Preferred Phone:_____ Other Phone:_____**

**Work Phone:_____ [ok to call? Y N ]**

- **Diagnosis of the patient, including stage if known**

**_____**

**_____**

- **Referring Physician or Clinician**

**_____**

- **Additional information:**

**_____**

**_____**

**_____**

**_____**

# ANDREA FELDMAR, LLC.

## PATIENT RIGHTS AND PRIVACY PRACTICES

I respect my clients' confidentiality and only release information about you in accordance with state and federal laws.

The following specifies your rights under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. **USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**
**For Treatment.** If you wish for me to provide information to another health care provider, Childs Rep, GAL or any legal entity, you will have to sign an authorization for release of information. Also, an authorization is required for most uses and disclosures of psychotherapy notes.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on release of information authorization. To revoke or cancel the release of information authorization, you must submit your request in writing to your mental health professional and your insurance company if you are submitting claims on your own, if applicable.

3. Once this information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

4. **Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.** HIPAA provides special protections or certain medical record known as "Psychotherapy Notes". All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as Psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from "Psychotherapy Notes" definitions are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished,(d) the results of clinical tests, (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and the progress date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign an authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical or mental health records.

5. **INFORMATION DISCLOSED WITHOUT YOUR CONSENT**
Under Florida and federal law, information about you may be disclosed without your consent in the following circumstances.
   a. **Emergencies.** Sufficient information may be shared to address an immediate emergency you are facing.
   b. **Judicial and Administrative proceedings.** I may disclose your personal health information in the course of a judicial or administrative proceeding in response to a valid court order or other lawful process, including if you were to make a claim for Workers Compensation.
   c. **Public Health Activities.** If I felt you were an immediate danger to yourself or others, I may disclose health information about you to the authorities, as well as to alert any other person who may be in danger,
   d. **Child/Elder Abuse.** I may disclose health information about you related to the suspicion of child and/or elder abuse or neglect.
   e. **Criminal Activity or Danger to others.** I may disclose health information if a crime is committed on my premises or against me personally, or if I believe there is someone who is in immediate danger.
   f. **National Security, Intelligence Activities, and Protective Services to the President and Others.** I may release health information about you to authorized federal officials as authorized by law in order to protect the President or other national or international figures, or in cases of national security.
   g. **Health Oversight Activities.** I may disclose health information to a health oversight agency for activities authorized by law. These activities might include audits or inspections and are necessary for the government to monitor the health care system and assure compliance with civil rights laws. Regulatory and accrediting organizations may review your case record to

ensure compliance with their requirements. The minimum necessary information will be provided in these instances.

h. **Scheduling Appointments**. I may use your phone number to call you and leave a message to schedule or remind you of appointments.

6. **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:**

**a.** **Right to Inspect and Copy.** You have the right to look at or get your health information, with limited exceptions. Your request must be in writing. If you request a copy of the information, a reasonable charge may be made for the costs incurred.

**b.** **Right to Amend.** You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I have the right to refuse your request under certain circumstances.

**c.** **Right to an Accounting of Disclosures.** You have the right to receive a list of instances in which I have disclosed your health information for a purpose other than treatment, payment, or health care operations. To request an accounting of disclosures, you must submit your request in writing to your therapist.

**d.** **Right of Notification.** You have the right to or will receive notifications of breaches of his or her unsecured Protected Health Information (PHI).

**e.** **Right to Request Restrictions.** You have the right to restrict certain disclosures of Protected Health Information to a health plan when you pay out of pocket in full for the healthcare item or service. While you are in treatment, a written request for the restriction should be made with your therapist. To request a restriction after therapy is completed, you must make your written request to your therapist.

**f.** **Right to Request Confidential Communications.** You have the right to request that I communicate with you about health matters in a certain way or at a certain location. For example, You may ask me that I contact you only by mail, email or at work. You must make this request in writing and it must specify the alternative means or location that you would like me to use to provide you information about your health care. I will make every attempt to accommodate reasonable requests.

**g.** **Right to Obtain a Paper Copy of this Notice.** You have the right to receive a paper copy of this notice and any amended notice upon request.

Any other uses and disclosures not set out in the information above will be made only with your written authorization. You may revoke written authorization for release of information at any time. The revocation must be in writing and will become effective when it has been received by Andrea Feldmar, LLC and will only be for disclosures not already comleted.

I reserve the right to change this privacy practices provided such changes are permitted by applicable law. Before the effective date of a material change, however, I will change this Notice and make a new Notice available to you . Beginning April 14, 2003 all practicing health care providers are required to abide by the terms of Notice.

**QUESTIONS and CONCERNS:**

If you have any questions or concerns you may contact the U.S. Department of Health & Human Services. To obtain additional information contact Andrea Feldmar at 941-208-2606

# MEDICAL SUPPORT COUNSELING
# ANDREA FELDMAR, LLC

## CONSENT FOR RELEASE OF INFORMATION

Client Name_____Birthdate_____

Address_____City,State_____zip_____

The Undersigned Authorizes Andrea Feldmar, LLC to release or obtain to/from:

Name_____ Phone Number_____

Address_____ _____

The following records and information concerning client, for period of:

m/d/y)_____(m/d/y)_____

The nature of the information to be released may be psychotherapy notes and communication, such as; telephone consultation, correspondence, treatment plans and/or follow up care.

This consent expires on_____20_____If no date is specified, the consent shall be valid only on the date received for this particular consent for release of information. I understand that I may revoke this consent in writing at any time but such revocation is effective only with respect to any future requests for disclosure and does not retroactively apply to any disclosure to _____in reliance on this release prior to the date it receives a revocation from me. I understand that any written revocation must be accompanied by the signature of a witness. I also understand that I may revoke this consent at any time, and that I have the right to inspect and copy the information to be disclosed.

**Authorization and Signature:**

**Printed name of client**_____

**Signature of client**_____**date**_____

**Printed Name of Witness**_____

**Witness Signature**_____**date**_____

Under the provisions of the Florida Mental Health Act, no person or agency to whom any of this information is disclosed may re-disclose such information unless the person who consented to this disclosure specifically consents to such re-disclosure.