

# Psychology \* Wellness Practice

Jennifer Smitkin, Psy.D  
Licensed Psychologist  
Certified School Psychologist

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## Patient Registration Form

<b>Name:</b>		<b>Date:</b>
<b>Street:</b>	<b>Suite/Apt. #</b>	<b>Date of Birth:</b>
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Phone (home):</b>	<b>Phone (work):</b>	
<b>Cell Phone:</b>	<b>Email Address:</b>	
<b>Name of person to call in an emergency:</b>		<b>Relationship:</b>
<b>Street:</b>		<b>Suite/Apt. #:</b>
<b>City:</b>	<b>State:</b>	<b>ZIP code:</b>
<b>Phone:</b>		
<b>Name of person filling out this form (if not patient):</b>		
<b>Name of Primary Care Physician (PCP):</b>		<b>Date last seen:</b>
<b>PCP Office Address:</b>		<b>Suite/Apt. #:</b>
<b>City:</b>	<b>State:</b>	<b>ZIP code:</b>
<b>Phone:</b>	<b>Fax:</b>	

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## Consent for Psychological Testing

- ❖ I, \_\_\_\_\_, give my consent to Dr. Jennifer Smitkin, to conduct psychological/psychoeducational testing and/or observations of me and/or my child \_\_\_\_\_.
- ❖ I understand that I may withdraw this consent at any time during the assessment or treatment process, but that I will still be financially obligated to pay for the services rendered.
- ❖ I understand that if this evaluation is being reimbursed by a third party (e.g., school district, agency) and I withdraw my consent to share the evaluation findings I am then financially obligated to pay for the entire assessment.
- ❖ I also understand that the assessment includes face-to-face time, as well as time needed for scoring, interpretation, and report writing. I understand that I will be responsible for copay or deductible on each billable hour (subject to vary depending on the time approved by your insurance company). I understand that I will be responsible for the full amount, if I choose to pay privately. I understand that I will need to pay my balance in full prior to receiving the psychological report, which will be discussed in a feedback session.
- ❖ My consent for testing and/or treatment will be terminated when revoked in writing.
- ❖ Insurance and school district payment sources need to be secured prior to the evaluation or consultation. Written confirmation of such approval is needed. Reimbursement for services rendered will be the responsibility of the patient and/or parent if this has not occurred.
- ❖ I agree to pay for this visit should there be denial of coverage by other sources.
- ❖ If I have any questions regarding the above, I will address them with Dr. Jennifer Smitkin at my first visit.

**Private Pay Clients Only:** It is requested that payment for services occur at the time of the office visit. Fee for school observation and consultation that occurs outside of the office will be included in the office visit fee.

\_\_\_\_\_  
Patient/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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## Adult Consent for Outpatient Services

Welcome to my practice! This document contains important information about my professional services and business policies. Please read it carefully and write down any questions you might have so that we can discuss them. When you sign this document, it will represent an agreement between us. First, it is noted that Psychology Wellness Practice, PLLC. rents office space to Independent Practitioners who share secretarial services. Psychology Wellness Practice, PLLC. has no other business relationship with Independent Practitioners. Protected Health Information (PHI) for Psychology Wellness Practice, PLLC. is not shared with Independent Practitioners unless an Authorization to Release Information Form is signed by the patient, typically for referral and/or consultative services. **MEETINGS:** I normally conduct an initial assessment, via clinical interview, that lasts 1-2 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your goals.

**CANCELLATION POLICY:** Most days, there is a waiting list of patients who are eager to set up an appointment as soon as possible. As such, it is important to keep your appointment for the time it was scheduled. Appointments that are cancelled more than 24 hours in advance will *not* be charged a cancellation fee. Appointments that are cancelled the day prior to your scheduled appointment but less than 24 hours in advance will be charged a \$30.00 cancellation fee. These calls must be received before 5:00pm the day prior to your appointment. Appointments that are cancelled the same day as scheduled are subject to a \$50.00 late cancellation fee. If you do not show to your scheduled appointment without a prior phone call, a \$90.00 fee is charged. In these cases, your credit or debit card will be charged automatically. Medicaid/Managed Medicaid patients are not charged these fees but will no longer be able to schedule appointments following the second of two missed appointments/no shows. Medicaid/Managed Medicaid patients who late cancel are also not charged a fee but must provide documentation (e.g., doctor's note, etc.), to justify the reason for cancellation, in order to continue scheduling appointments. More than one late cancellation without justified documentation will result in the Medicaid/Managed Medicaid client to be terminated from treatment. Child Health Plus patients *are* subject to all fees. **PROFESSIONAL FEES:**

**Out-of-network:** If I do not accept your insurance, I can still provide my services as an out of network provider. In that case, my fee for psychotherapy sessions is \$150.00. My fee per hour of psychological testing and consultation is \$170.00. Classroom observations are never a covered entity under health insurance. My fee for a classroom observation is \$200.00. Phone calls, emails, general letters to patients and collaterals (e.g., school personnel, PCP or other physicians), and review of records are billed at a rate of \$25.00 per 15 minutes. **Insurance:** Co-pay is required at the time of service for each session. I accept cash or check on the day of service. Please make checks payable to Psychology Wellness Practice, PLLC. Co-pays not paid at the time of service will be subject to a \$10.00 late payment charge. Both the copay and the late payment charge will be charge automatically to your credit/debit card. Late copays can also be charged to your health savings account if that card is on file here. **Other:** Insurance companies do not reimburse for phone calls between you and I involving treatment matters that are discussed outside of scheduled sessions, nor do they reimburse for preparation of records for a third party or at your request. Insurance companies also do not reimburse for phone calls or emails to collaterals (e.g., school personnel, PCP or other physicians), even when part of a psychological evaluation. As such, those services are billed at a private pay rate of \$25.00 per 15 minutes. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, even if I am called to testify by another party, at my then current rates per hour of time. I do not, however, become involved in child custody matters. **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 insurance coverage that requires another arrangement. Please refer to the Credit/Debit Card Payment Agreement form for detailed information about how outstanding balances are charged. **INSURANCE REIMBURSEMENT:** In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental (behavioral) health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental (behavioral) health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental (behavioral) health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. It may be necessary to seek approval for more therapy after a certain number of sessions. You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. I will provide you with a copy of any report I submit, if you request it. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above. **OFFICE HOURS:** Psychology Wellness Practice, PLLC. is open Monday through Thursday. The office is closed when the North Colonie Central School District closes due to snow. If the North Colonie Central School District has a delayed opening or dismisses early, our office conducts business as usual. **CONTACTING ME:** I am often not immediately available by telephone. When I am unavailable, the office telephone is answered by voice mail or by one of our secretaries. I will make every effort to return your call within one business day, with the exception of Fridays, weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychiatrist/psychologist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. **ELECTRONIC COMMUNICATIONS:** Various types of electronic communications are common in our society, and many individuals

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believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law. **Email Communications:** I use email communication only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication. **Text Messaging:** Since text messaging is a very unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages from anyone in treatment with me. So, please do not text message me unless we have made other arrangements. **Social Media:** I do not communicate with, or contact, any of my patients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you. I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with patients online have a high potential to compromise the professional relationship. **CONFIDENTIALITY:** In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child is being abused, I must file a report with the appropriate state agency. If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

**Statement of Release by Parent/Guardian to Insurance Company:** I request that payment of authorized insurance benefits be made on my child's behalf to Psychology Wellness Practice, PLLC/ Jennifer Smitkin, Psy.D for services furnished to me by this practitioner. I authorize Jennifer Smitkin, Psy.D to release medical and psychological information about my child to the applicable insurance company should any information be needed to determine these benefits. By signing this consent, I acknowledge that I have read it and the Notice of Privacy Practices, or that they have been read to me, that I am at least 18 years old (or, if under 18, married or the parent of a child), that I understand the above agreement, and that I am signing this consent voluntarily.

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Parent/Guardian Signature

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Date

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Witness Signature

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## Credit/Debit Payment Agreement

Patient Name

Patient Date of Birth

\_\_ I authorize Psychology Wellness Practice, PLLC. to keep my signature on file and to charge my Visa, MasterCard, American Express or Discover listed below for DEDUCTIBLE, COINSURANCE, COPAYMENT, OUT OF POCKET COSTS (e.g., late fees, described below; insufficient funds checks and fees; non-covered medical entities, reviewed in the Outpatient Services Contract), and/or LATE CANCELLATION/NO SHOW amounts due on the account of the patient named above. The card(s) may be charged **automatically** after the original time and date of service if payment was not provided at the time of service. **I understand that only cash and check are accepted at the time of service. Note that balances not paid at the time of service will be charged a \$10.00 late fee.** Receipts will be sent upon payment processing to the email address indicated below. I may continue to schedule appointments provided my credit card remains on file, is valid, and additional fees are not accrued.

\_\_ I authorize Psychology Wellness Practice, PLLC to keep my signature on file and to charge my Health Savings Account listed below for DEDUCTIBLE, COINSURANCE, and COPAYMENT only. The card may be charged **automatically** after the original time and date of service if payment was not provided at the time of service. **I understand that only cash and check are accepted at the time of service. Note that balances not paid at the time of service will be charged a \$10.00 late fee, charged to the Visa, MasterCard, American Express, or Discover listed below.** Receipts will be sent upon payment processing to the email address indicated below. I may continue to schedule appointments provided my Health Savings Account remains on file, is valid, and additional fees are not accrued.

Visa, MasterCard, American Express, Discover (circle One)

Card #: \_\_\_\_\_

Card Expiration Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

CV (back of card): \_ \_ \_

Billing Zip Code: \_\_\_\_\_

Visa, MasterCard, American Express, Discover (circle One)

Card #: \_\_\_\_\_

Card Expiration Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

CV (back of card): \_ \_ \_

Billing Zip Code: \_\_\_\_\_

I understand this form is valid unless I cancel this authorization by written notice. If I choose to cancel this form, I assume full responsibility for paying the above named patient charges in full at the time of service or I will make alternative arrangements for payment. I further understand that withdrawal of this authorization OR declination of my credit/Health Saving Account card upon payment processing will affect my ability to schedule appointments and may result in cancellation of future appointments. I must provide an email address to which receipts will be sent upon payment processing.

Cardholder Name

Cardholder's Relationship to Patient

Cardholder Billing Address

City, State Zip

Signature of Cardholder

Date

Email address (required): \_\_\_\_\_

I have read and agree to the terms of the payment option(s) I have chosen above and acknowledge that I will be provided with a signed copy of this election form.

Signature of Patient

Relationship to Patient

Date

(Parent/Guardian if Patient is under 18 yrs old)

Staff Initials and Date: \_\_\_\_\_ Copy Provided: YES/NO

Psychology Wellness Practice, PLLC

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## AUTHORIZATION FOR RELEASE OF INFORMATION

I, \_\_\_\_\_, authorize Jennifer Smitkin, Psy.D to release and obtain the health information described below to:

<b>Name</b>	
<b>Contact Info</b>	

This request and authorization applies to only the following protected health information:

\_\_\_\_\_

\_\_\_\_\_

List each purpose or reason for the use or release of the protected health information:

\_\_\_\_\_

\_\_\_\_\_

This authorization shall remain in full effect until the end of our treatment relationship or it will expire 5 years from today, whichever comes first.

I understand that, except with respect to action already taken in reliance on this authorization, I may revoke this authorization in writing at any time by delivering or sending written notification to:

Jennifer Smitkin Psy.D, 950 New Loudon Rd., Suite 101, Latham, NY 12110 Email: [jsmitkin@pwpractice.com](mailto:jsmitkin@pwpractice.com)

I understand that Jennifer Smitkin, Psy.D may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is related to the research project.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

If this authorization is for the release of HIV-related information, the recipient of the information is prohibited from redisclosing any HIV-related information about you without your authorization unless permitted to do so by federal or state law.

I understand that I have the right to receive a copy of this authorization after I have signed it. I understand that a copy of this authorization will be maintained in my patient record.

I understand that I have the right to refuse to sign this authorization.

\_\_\_\_\_  
Patient's signature (relationship if signed by parent / guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness signature

\_\_\_\_\_  
Date



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1500

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA									
1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Recipient's SSN) <input type="checkbox"/> CHAMPVA (Member ID) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BULKING (BSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DO YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No. Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY										7. INSURED'S ADDRESS (No. Street)									
STATE										8. INSURED'S NAME (Last Name, First Name, Middle Initial)									
ZIP CODE										9. INSURED'S STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>									
TELEPHONE (Include Area Code)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>									
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DO YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
b. OTHER INSURED'S DATE OF BIRTH MM DO YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. EMPLOYER'S NAME OR SCHOOL NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 8 a-d									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other to myself or to the party who accepts assignment below.																			
SIGNED										SIGNED									
14. DATE OF CURRENT CLAIM (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DO YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DO YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DO YY TO MM DO YY									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by line) 1. _____ 2. _____ 3. _____ 4. _____										22. MEDICARE RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From MM DO YY To MM DO YY B. PLACE OF SERVICE EMS C. PROCEDURE, SERVICE, OR SUPPLY (Explain Unusual Circumstances) GPT/HCP/PS MODIFIER D. DIAGNOSIS POINTER										25. PRIOR AUTHORIZATION NUMBER									
26. FEDERAL TAX I.D. NUMBER SSN EIN										27. ACCEPT ASSIGNMENT? For 2004-2005, see back YES <input type="checkbox"/> NO <input type="checkbox"/>									
28. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										29. TOTAL CHARGE \$									
30. SERVICE FACILITY LOCATION INFORMATION										31. BILLING PROVIDER INFO & PIN # ( )									
32. BILLING PROVIDER INFO & PIN # ( )										33. AMOUNT PAID \$									
34. BALANCE DUE \$										35. DATE									

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

Printed on Recycled Paper

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

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**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 the Privacy Contact who is: Jennifer Smitkin, Psy.D**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

## 1. Uses and Disclosures of Protected Health Information

### Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your physician to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.



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## **Uses and Disclosures of Protected Health Information Based upon Your Written Authorization**

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## **Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object**

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

**Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

**Emergencies:** We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

**Communication Barriers:** We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

## **Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object**

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

**Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

# Psychology \* Wellness Practice

Jennifer Smitkin, Psy.D  
Licensed Psychologist  
Certified School Psychologist

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**Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

**Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

**Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

**Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

**Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

## **2. Your Rights**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

**You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

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**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

**You may have the right to have your physician amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

#### **Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

# Psychology \* Wellness Practice

*Independent Practitioners Integrated for Health and Wellness*

**Jennifer Smitkin, Psy.D 950 New Loudon Road, Suite 101, Latham, NY 12110 518.608.4171 518.608.4269 (fax)**

## Credit/Debit Payment Agreement

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**Patient Date of Birth**

\_\_\_ I authorize Psychology Wellness Practice, PLLC. to keep my signature on file and to charge my Visa, MasterCard, American Express or Discover listed below for DEDUCTIBLE, COINSURANCE, COPAYMENT, OUT OF POCKET COSTS (e.g., late fees, described below; insufficient funds checks and fees; non-covered medical entities, reviewed in the Outpatient Services Contract), and/or LATE CANCELLATION/NO SHOW amounts due on the account of the patient named above. The card(s) may be charged **automatically** after the original time and date of service if payment was not provided at the time of service. **I understand that only cash and check are accepted at the time of service. Note that balances not paid at the time of service will be charged a \$10.00 late fee.** Receipts will be sent upon payment processing to the email address indicated below. I may continue to schedule appointments provided my credit card remains on file, is valid, and additional fees are not accrued.

\_\_\_ I authorize Psychology Wellness Practice, PLLC to keep my signature on file and to charge my Health Savings Account listed below for DEDUCTIBLE, COINSURANCE, and COPAYMENT only. The card may be charged **automatically** after the original time and date of service if payment was not provided at the time of service. **I understand that only cash and check are accepted at the time of service. Note that balances not paid at the time of service will be charged a \$10.00 late fee, charged to the Visa, MasterCard, American Express, or Discover listed below.** Receipts will be sent upon payment processing to the email address indicated below. I may continue to schedule appointments provided my Health Savings Account remains on file, is valid, and additional fees are not accrued.

\_\_\_\_\_  
Visa, MasterCard, American Express, Discover (circle One)

Card #: \_\_\_\_\_

Card Expiration Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

CV (back of card): \_ \_ \_

Billing Zip Code: \_\_\_\_\_

\_\_\_\_\_  
Visa, MasterCard, American Express, Discover (circle One)

Card #: \_\_\_\_\_

Card Expiration Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

CV (back of card): \_ \_ \_

Billing Zip Code: \_\_\_\_\_

I understand this form is valid unless I cancel this authorization by written notice. If I choose to cancel this form, I assume full responsibility for paying the above named patient charges in full at the time of service or I will make alternative arrangements for payment. I further understand that withdrawal of this authorization OR declination of my credit/Health Saving Account card upon payment processing will affect my ability to schedule appointments and may result in cancellation of future appointments. I must provide an email address to which receipts will be sent upon payment processing.

\_\_\_\_\_  
Cardholder Name

\_\_\_\_\_  
Cardholder's Relationship to Patient

\_\_\_\_\_  
Cardholder Billing Address

\_\_\_\_\_  
City, State Zip

\_\_\_\_\_  
Signature of Cardholder

\_\_\_\_\_  
Date

**Email address (required):** \_\_\_\_\_

I have read and agree to the terms of the payment option(s) I have chosen above and acknowledge that I will be provided with a signed copy of this election form.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

(Parent/Guardian if Patient is under 18 yrs old)

**Staff Initials and Date:** \_\_\_\_\_ **Copy Provided: YES/NO**