Psychology * Wellness Practice

Jennifer Rickert, Psy.D
Licensed Psychologist
Certified School Psychologist

Child Registration Form

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

Insurance Information:

Insurance Company:	**Ins. Phone:**
Subscriber:	**ID #:**
Subscriber's Employer:	**Birth Date:**
Patient's relationship to subscriber:	
Secondary Insurance Company:	**ID#:**

Statement of Release by Patient to Insurance Company

I request that payment of authorized insurance benefits be made on my behalf to Jennifer Rickert, Psy.D for services furnished to me by this practitioner. I authorize Jennifer Rickert, Psy.D to release medical information about me to the applicable insurance company should any information be needed to determine these benefits. Please be advised that only the minimum necessary information will be disclosed to serve these administrative purposes.

I acknowledge that the above information I have provided is correct.

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Date

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Consent for Psychological Testing

- I, _____, give my consent to Dr. Jennifer Rickert, 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.

Printed Name

Signature

Witness

Date

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Psychological Testing Payment Agreement

I, _____, am under the impression that the cost of the evaluation or consultation for myself/my child, _____ will be covered by:

Please Check One:

☐ **School District** ☐ **Insurance** ☐ **Private Pay**

Please Note

- 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 Rickert 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.

I understand that if the cost of this evaluation or consultation is being covered by a school district or insurance company and I rescind my consent to disclose information generated from the evaluation or consultation (e.g., IQ score, achievement scores, social-emotional status) upon completion of the evaluation, I may be held financially responsible for the cost of the evaluation or consultation.

_____ _____
Signature of Patient/Parent or Guardian Date

_____ _____
Witness Date

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Outpatient Services Contract

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.

PSYCHOLOGICAL SERVICES
Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. Our first session will involve an evaluation of your needs. By the end of that process, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS
I normally conduct an initial diagnostic assessment, via clinical interview, that lasts 1 session. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-minute session (one appointment hour of 45 minutes duration) for family therapy and one 53-60 minute session for individual therapy. Sessions will be scheduled at a time we agree on, although some sessions may be longer or shorter, or more or less frequent.

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. Appointments that are cancelled the same day as scheduled will be charged a $90.00 cancellation fee. The fees will be waived if the appointment is able to be filled by another patient and under extreme circumstances that are agreed upon between you and I.

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 $100.00. My fee for psychological testing and consultation is $170.00. Phone calls, emails, and general letters to patients and collaterals (e.g., school personnel, PCP or other physicians) are billed at a rate of $25.00 per 15 minutes.

Insurance: Co-pay is required for each psychotherapy and psychological testing session **at the time of service**. A $10.00 charge will be applied to all copays not paid at the time of service. **I accept cash and personal check. Please make checks payable to Psychology Wellness Practice, PLLC.**

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 psychotherapy session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

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. If it is necessary to clear confusion, I will be willing to call the company on your behalf. Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental (behavioral) health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental (behavioral) health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. 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. In some cases, they may share the information with a national medical information databank. 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.

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 receptionists. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. 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 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.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead, unless I determine that to do so may cause emotional harm. Since these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. You should be aware that this will be treated in the same manner as any other professional service, and you will be charged an appropriate fee (see PROFESSIONAL FEES above).

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss. At the end of your treatment, I will prepare a summary of our work together for your parents, and we will discuss it before I send it to them.

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. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings

involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it. However, I do not conduct child custody evaluations nor do I involve myself in related legal proceedings. Should I be contacted by your counsel or another for such a matter, you will be responsible for payment for the amount of time I am in correspondence with counsel, even if it is to explain that I do not become involved in child custody matters. 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. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

I understand and agree to the information provided in this document.

_____ _____

Patient/Parent Signature **Date**

_____ _____

Witness Signature **Date**

Psychology * Wellness Practice

Jennifer Smitkin, Psy.D
Licensed Psychologist
Certified School Psychologist

Patient Request for Confidential Communications

- It is assumed that Dr. Jennifer Rickert, may contact you by telephone at your home and at your work, and in writing at your home, unless you inform her otherwise.

- Under HIPPA, you have the right to request that communications with you be confidential and by means acceptable to you. Dr. Jennifer Rickert will approve your request if it is feasible and mutually agreeable. Dr. Jennifer Rickert will honor your request, unless you specify you would like her to contact you if an emergency arises.

I wish to be contacted as follows:

- ☐ At my home telephone number _____
  - ☐ You can leave messages with detailed information.
  - ☐ Leave message with call-back number only.
  - ☐ Call only at specified times of day _____
- ☐ At my mobile (cell) telephone number _____
  - ☐ You can leave messages with detailed information.
  - ☐ Leave message with call-back number only.
  - ☐ Call only at specified times of day _____
- ☐ At my work telephone number
  - ☐ You can leave messages with detailed information.
  - ☐ Leave messages with call-back number only.
  - ☐ Call only at specified times of day _____
- ☐ In writing
  - ☐ My home address
  - ☐ My work address
  - ☐ My fax number(s) _____
  - ☐ My email address _____

_____ _____
Signature of Patient/Parent or Guardian Date

_____ _____
Witness Date

Jennifer Rickert, Psy.D
Licensed Psychologist
Certified School Psychologist

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, authorize Jennifer Rickert, Psy.D to obtain from and release the health information described below to:

Name	
Contact Info	

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 Rickert Psy.D, 950 New Loudon Rd., Suite 101, Latham, NY 12110 Email: jmrickertpsyd@gmail.com

I understand that Jennifer Rickert, 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

Jennifer Rickert, Psy.D.
950 New Loudon Road
Suite 101
Latham, NY 12110
(Phone) 518.608.4271/ (Fax) 518.608.4269

I. Family Data

Child's Name:_____ Today's Date:_____

Grade:_____ Date of Birth:_____

Age: _____ Home phone:_____

Address:_____

Person filling out this form:_____ Relation to child: _____

Mother's name:_____ Occupation_____

Home phone: _____ Business phone:_____

Cell phone:_____

Father's name:_____ Occupation_____

Home phone: _____ Business phone _____

Cell phone:_____

Marital status of parents: _____

If parents are separated or divorced, how old was the child when the separation occurred? _____

What is the current custody arrangement?_____

Is the child adopted ? Yes No If yes, child's age when adopted_____

Please describe any specific information about the adoption (e.g., significant events prior to adoption, etc.)

_____

List all people living in the household:

Name	Relationship to child	Age

If any brothers or sisters are living outside the home, list their names and ages:_____

Primary language spoken in the home:_____

Below, please specify family members (e.g., child's sister, maternal aunt, paternal grandmother) that have experienced any of the following:

	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Difficulties learning to read					
Difficulties in math					
Difficulties in writing					
Depression					
Anxiety					
Attentional Difficulties					
Hyperactivity					
Emotional/behavior Problems					
Autism					

II. Presenting Problem

Please list your child's current diagnoses, if any. _____

Diagnosis	**Date Diagnosed**	**Physician/Psychologist who made Diagnosis**

Briefly describe your child's current difficulties:

_____

_____

How long has this problem been of concern to you?_____

What do you believe to be the primary issues contributing to those difficulties?_____

What has been done to address the problem?

At home?_____

At school?_____

Has the child received evaluation or intervention/counseling services for the current problem or similar problems?

Yes No

If yes, when and with whom? _____

III. Developmental History

Were there any prenatal difficulties? Yes No If yes, please describe _____

Were forceps used during delivery? Yes No

Was a Caesarean section performed? Yes No If yes, for what reason? _____

Was the child premature? Yes No If so, by how many months? _____

What was the child's birth weight? _____

Were there any birth defects or complications? Yes No If yes, please describe:_____

Were there any special problems in the growth and development of the child during the first few years?

Yes No

If yes, please describe:_____

To your knowledge, at approximately what age did your child attain the following developmental milestones?

Spoke single words_____ Said short sentences (2 to 3 words)_____

Walked without assistance_____ Became toilet trained_____

What disciplinary techniques do you find to be successful with your child?_____

_____

_____

IV. Medical History

Place a check next to any health problems that the child has had or has now. When you check an item, also note the approximate age at which the child developed the illness.

Condition	√	**Age**	**Condition**	√	**Age**
High Fever			Eye/Vision Difficulties		
Recurrent Ear Infections			Speech Problems		
Seizures			Allergies		
Head Injury			Asthma		
Loss of Consciousness			Headaches		

Is the child on any medication at this time? Yes No

If yes, please note kind of medication: _____

Is your child generally in good health? Yes No If no, please explain_____

Has your child ever had a serious illness, been hospitalized, or had surgery? Yes No

If yes, please explain:_____

Name of child's Primary Care Physician_____ Phone:_____

Date of child's last physical exam:_____ Did exam reveal normal results? Yes No

If no, please explain:_____

Does your child require the use of glasses/contacts? Yes No

V. Social and Behavior Checklist

Directions: Please place a checkmark to indicate which issues apply to your child at this time.

__Depression	__Communication Difficulties
__Suicidal thoughts or actions	__Low Self-Esteem
__Anxious/Worried	__Issues related to custody/visitation
__Moody/Sad	__Victim of sexual abuse
__Panic Attacks or Intense Fears	__Domestic violence (verbal, physical, threats)
__Anger Problems, quick temper	__Conduct Problems, in trouble with the law
__Physically fighting with others	__Eating Disorder Symptoms
__Outbursts or Explosive Behavior	__Family Problems
__Alcohol/other drug abuse	__Parent Drug/Alcohol abuse
__Behavioral difficulties in school	__Academic difficulties in school
__School Problems __Truancy or School Avoidance __Suspensions or Expulsion __Learning Disabilities __Problems with attention __Lack of work completion at school __Lack of homework completion __Not listening to teacher __Fighting at school __Victim of bullying __Demonstrates bullying behavior	__Family Problems __Conflicts with mother __Conflicts with father __Conflicts with step-parent __Parents having marital problems __Problems with brother/sister __Running away from home __Disobedient __Verbal Aggression __Physical Aggression __Domestic violence
__Death of a loved one	__Toileting Accidents
__Major losses/difficult changes	__Fire Setting
__Frequent stealing, lying, cheating	__Shy, clingy, wants to be with parents
__Very active, possibly hyperactive	__Sleep Difficulties
__Problems with Friends	__Doesn't think before acting
__Does not appear sorry for actions	__Does cruel or strange things

__Bangs head	__Easily frustrated
__Cuts or burns self	__Other:

Sources of Stress:

Please list any things/events/problems that are creating stress in your child's and/or your family's lives at the present time (include significant losses and changes). If none, please indicate that.

_____
_____
_____
_____

VI. Relationships:

Please use a checkmark to indicate which statements apply to your child at this time.

__Too few friends	__Enough friends
__Friends are part of support system	__Doesn't share problems with friends
__Overly Shy	__Finds it difficult to open up to others
__Makes friends easily	__Finds it hard to keep friends
__Spends time with peers of a similar age	__Prefers younger companions
__Prefers older companions	__Is susceptible to peer influence
__Is a leader among friends	__Friends are a negative influence, "bad crowd"

VII. Educational History

Please list all schools that your child has attended, including preschool and nursery school experiences.

Name of School Location/District Dates Attended/Grades Completed

_____
_____
_____
_____
_____

Has your child ever repeated a grade? Yes No If yes, what grade and why? _____

Has your child ever had an Individualized Education Plan?

Has your child ever received special tutoring or therapy in school? Yes No

If so, please indicate below:

___Remedial Reading ___Speech Therapy ___Occupational Therapy
___ Physical Therapy ___Counseling Services ___Behavioral Supports

What are your child's assets or strengths? _____

_____

Is there any other information that you think may help us in working with your child?

_____

_____

Date:_____ Signature: _____

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)	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 DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ☐ NO ☐	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 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 either to myself or to the party who accepts assignment below. SIGNED _____ DATE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 3. 2. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH # ( ) a. b.		

Psychology * Wellness Practice

Jennifer Rickert, Psy.D
Licensed Psychologist
Certified School Psychologist

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND SAFEGUARDED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Our Responsibility

The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care, such as a record of your symptoms, examination and test results, diagnoses, treatments and referrals for further care. It also includes bills, insurance claims, or other payment information that we maintain related to your care.

This Notice describes how we handle your health information and your rights regarding this information. Generally speaking, we are required to:

- Maintain the privacy of your health information as required by law;
- Provide you with this Notice of our duties and privacy practices regarding the health information about you that we collect and maintain; and
- Follow the terms of our Notice currently in effect.

II. Our Contact Information

After reviewing this Notice, if you need further information or want to contact us for any reason regarding the handling of your health information, please direct any communications to the following contact person:

Privacy Officer: Jennifer Rickert, Psy.D 950 New Loudon Rd., Latham, NY 12110 (518) 608-4271

III. Uses and Disclosures of Information

Federal law permits us to use and disclose personal health information without your consent or authorization for purposes of treatment, payment, and health care operations. However, under New York State law and regulations, we will not release your personal health information to any third party except in the following circumstances:

1. With Your Express Consent for Treatment and Payment Purposes

This consent may be in writing, oral or implied.

Examples:

- You send us a written request to send a copy of your records to another physician who may be providing treatment to you
- You ask us to call the pharmacy to renew your medication

- You ask us to submit a health insurance claim form to your insurance carrier or you seek treatment from us because we are a participating provider in your health plan

2. For Health Care Operations

In the course of providing treatment to you, we may need to share information with our employees, including students and trainees, and consultants to perform the operations of our medical office. We will share with our employees and business associates only the minimum amount of personal health information necessary for them to assist us.

Examples:

- To bill for our services
- To set up appointments with you

3. As Otherwise Permitted or Required by Federal or State Law or Regulation

Examples:

- In an emergency situation
- For child abuse and neglect reporting and investigation

4. Pursuant to Your Written Authorization

We will not release health information to any third party In connection with any other uses and disclosures not described in this Notice, unless you grant us written authorization to do so.

Examples:

- We receive a request for medical information from your potential employer
- In connection with use or disclosure of psychotherapy notes
- In connection with marketing activities
- In connection with the sale of protected health information

IV. Other Uses and Disclosures

In addition to uses and disclosures related to treatment, payment, and health care operations, we also may use and disclose your personal information without your express consent or authorization for the following additional purposes:

Abuse, Neglect, or Domestic Violence
As required or permitted by law, we may disclose health information about you to a state or federal agency to report suspected abuse, neglect, or domestic violence. If such a report is optional, we will use our professional judgment in deciding whether or not to make such a report. If feasible, we will inform you promptly that we have made such a disclosure.

Appointment Reminders and Other Health Services
We may use or disclose your health information to remind you about appointments or to inform you about treatment alternatives or other health-related benefits and services that may be of interest to you, such as case management or care coordination.

Business Associates
We may share health information about you with business associates who are performing services on our behalf. For example, we may contract with a company to do our billing. Our business associates are obligated to safeguard your health information. We will share with our business associates only the minimum amount of health information necessary for them to assist us.

Communicable Diseases
To the extent permitted or required by law, we may disclose information to a public health official or a person who may have been exposed to a communicable disease or who is otherwise at risk of spreading a disease or condition.

Communications with Family and Friends
We may disclose information about you to a person who is involved in your care or payment for your care, such as family members, relatives, or close personal friends. In addition, we may notify a family member, your personal representative, or other person responsible for your care, of your location, general condition, or death. Any such disclosure will be limited to information directly related to the person's involvement in your care. If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated or because of some other emergency circumstance, we will use our professional judgment to determine what is in your best interest regarding any such disclosure.

Coroners, Medical Examiners and Funeral Directors
In the event of your death, we may disclose health information about you to a coroner or medical examiner, for example, to assist in identification or determining cause of death. We may also disclose health information to funeral directors to enable them to carry out their duties.

Disaster Relief
We may disclose health information about you to government entities or private organizations (such as the Red Cross) to assist in disaster relief efforts. If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated, we will use our professional judgment to determine what is in your best interest and whether a disclosure may be necessary to ensure an adequate response to the emergency circumstances.

Food and Drug Administration (FDA)
We may disclose health information about you to the FDA, or to an entity regulated by the FDA, for example, in order to report an adverse event or a defect related to a drug or medical device.

Health Oversight
We may disclose health information about you for oversight activities that are authorized by federal or state law, for example, to facilitate auditing, inspection, or investigation related to our provision of health care, or to the health care system.

Judicial or Administrative Proceedings
We may disclose health information about you pursuant to a court order in connection with a judicial or administrative proceeding, in accordance with our legal obligations.

Law Enforcement
We may disclose health information about you to a law enforcement official for certain law enforcement purposes without your consent but only if you are incapacitated or in an emergency situation.

Minors
If you are an unemancipated minor under New York law, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting *in loco parentis*, in accordance with our legal and ethical responsibilities.

Parents
If you are a parent of an unemancipated minor, and are acting as the minor's personal representative, we may disclose health information about your child to you under certain circumstances. For example, if we are legally required to obtain your consent as your child's personal representative in order for your child to receive care from us, we may disclose health information about your child to you. In some circumstances, we may not disclose health information about an unemancipated minor to you. For example, if your child is legally authorized to consent to treatment (without separate consent from you),
consents to such treatment, and does not request that you be treated as his or her personal representative, we may not disclose health information about your child to you without your child's written authorization.

Personal Representative
If you are an adult or emancipated minor, we may disclose health information about you to a personal representative authorized to act on your behalf in making decisions about your health care.

Public Health Activities
As required or permitted by law, we may disclose health information about you to a public health authority, for example, to report disease, injury or vital events such as death.

Public Safety

Consistent with our legal and ethical obligations, we may disclose health information about you based on a good faith determination that such disclosure is necessary to prevent a serious and imminent threat to yourself, to identified individuals and the public, or in an emergency situation.

Required By Law
We may disclose health information about you as required by federal, state or other applicable law.

Specialized Government Functions
We may disclose health information about you for certain specialized government functions, as authorized by law and depending on the particular circumstances. Examples of specialized government functions include military activities, determination of veterans benefits and emergency situations involving the health, safety, and security of public officials.

Workers' Compensation
We may disclose health information about you for purposes related to workers' compensation, as required and authorized by law.

V. Your Health Information Rights

Under the law, you have certain rights regarding the health information that we collect and maintain about you. This includes the right to:

- Request that we restrict certain uses and disclosures of your health information. We are not, however, required to agree to all requested restrictions, unless the requested restriction involves information to be sent to a health plan for payment or health care operations purposes and the

disclosure relates to products or services that were paid for in full and such disclosure is not otherwise required by law.

- Request that we communicate with you by alternative means, such as making records available for pick-up, or mailing them to you at an alternative address, such as a P.O. Box. We will accommodate reasonable requests for such confidential communications.

- Request to review, or to receive a copy of, the health information about you that is maintained in our files and used to make decisions about your treatment. We will respond to your request to inspect records within 10 days. We ordinarily will respond to requests to copy records within 30 days for on-site records and 60 days for off-site records. The standard fee for copying is $0.75 per page. If we maintain an electronic health record for you, you may request access to your health information in an electronic format or have the information transmitted electronically to a designated recipient. Any fee charged by us for the electronic document production will not exceed our labor costs in responding to the request. If we are unable to satisfy your request, we may instead provide you with a summary of the information you requested. We will also tell you in writing the reason for the denial and your right, if any, to request a review of the decision and how to do so.

- Request that we amend the health information about you that is maintained in our files. Your request must explain why you believe our records about you are incorrect, or otherwise require amendment. Ordinarily, we will respond to your request for an amendment within 60 days. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and tell you how you may contest the decision, including your right to submit a statement (of reasonable length) disagreeing with the decision. This statement will be added to your records.
- Request a list of our disclosures of your health information. This list, known as an "accounting" of disclosures, will not include certain disclosures, such as routine disclosures made for payment, treatment or health care operations purposes or those made pursuant to a written authorization. However, if we maintain an electronic health record for you, you may be entitled to receive an accounting of routine disclosures of your health information. We will ordinarily respond to your request for an accounting of disclosures within 60 days. We will provide you the accounting free of charge, however if you request more than one accounting in any 12 month period, we may impose a reasonable, cost-based fee for any subsequent request. Your request should indicate the period of time in which you are interested (for example, "from May 1, 2013 to June 1, 2013"). We will be unable to provide you an accounting for any disclosures made before April 14, 2003, or for a period of longer than six years.

- Request a paper copy of this Notice.

In order to exercise any of your rights described above, you must submit your request in writing to our contact person (see section II above for information). If you have questions about your rights, please speak with our contact person, available in person or by phone, during normal office hours.

VI. Notice of Breach of Health Information

In the unlikely event that your health information is inadvertently acquired, accessed, used by, or disclosed to an unauthorized person, we will provide you with written notice of such breach. The notice will be sent without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. The notice will be written in plain language and will contain the following information: (i) a brief description of what happened, the date of the breach, if known, and the date of discovery; (ii) the type of

PHI involved in the breach; (iii) any precautionary steps you should take; (iv) a description of what we are doing to investigate and mitigate the breach and prevent future breaches; and (v) how you may contact us to discuss the breach.

The written notice of breach will be sent by regular mail or by email if you have indicated that you prefer to receive communications from us by email. If the contact information we maintain for you is insufficient or out-of-date, we may attempt to provide notice to you by telephone or other permissible alternate method. We will also report the breach to the U.S. Department of Health and Human Services.

VII. To Request Information or File a Complaint

If you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to our contact person (see section II above). You may complain to the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F Washington, D.C. 20201; by calling 1-800-368-1019; or by sending an email to OCRprivacy@hhs.gov. We cannot, and will not, make you waive your right to file a complaint with HHS as a condition of receiving care from us, or penalize you for filing a complaint with HHS.

VIII. Revisions to this Notice of Privacy Practices

We reserve the right to amend the terms of this Notice. If this Notice is revised, the amended terms shall apply to all health information that we maintain, including information about you collected or obtained before the effective date of the revised Notice. We will post any revised Notice in the waiting areas of our office. You will also be able to obtain your own copy of the revised Notice by contacting us or asking for one at your next visit. If we revise or update the Notice with a material change, we will re-distribute the Notice to all patients. If the revision or update is non-material, we will provide the new Notice to all new patients at the first date of service and to all currents patients only upon request.

IX. Effective Date

This Notice will take effect on September 23, 2013.