Helene Cohen, Psy.D. LLC and Associates
7890 Peters Road, Suite G-107
Plantation, FL 33324
Office (954) 577-0075

Client Name: _____ (Mr.) (Mrs.) (Ms.) (Dr.) Date: _____

Address: _____ City _____State _____Zip_____

Phone Number: Home (___)_____ Cell (___)_____ Leave Message (Y) (N)

Age _____ Date of Birth _____Email address: _____

Are there any restrictions on how we may contact you: (Y) (N) If yes, please explain_____

Gender ____ M _____F Social Security Number: _____

Marital Status: (Single) (Divorced) (Widow) (Married) Spouse / Partners Name:_____

Check all that apply: ( ) Employed ( ) Retired ( ) Full Time Student ( ) P/T Student ( ) Other

Employer / School: _____ Occupation / Grade:_____

If employed, how long have you worked there? _____

Please indicate the highest level of education you have completed to date: _____

Primary Care Physician: _____Phone:_____

Current or recent health concerns: _____

Current medications: _____

Do we have your permission to contact your PCP regarding your treatment: (Y) (N) Are you

seeing other physicians for treatment (Y) (N). If yes, please print names and reason for treatment.

_____

Whom can we thank for referring you to our office?_____

What is the primary reason for your visit today? _____

When was the last time your recall feeling emotionally well? _____

Have you ever considered or attempted harming yourself or someone else? ___ Yes ____No When ? _____

What do you hope to achieve from our work together? _____

In case of a medical emergency, who should we call? _____

PLEASE SIGN BELOW

If client is a minor; please affirm that you have the authority to make informed consent decisions:

Signature:_____Relationship: _____ Date:_____

FINANCIAL INFORMATION

Credit card information MUST be placed in the following section for clinical services to be rendered

Please accept my signature below as authorization to bill my __Visa __Master card (No AMEX/Discover)

Account # _____Expiration Date _____CVV _____

for therapeutic/assessment services in the amount of $_____ as they occur for the

following client(s)_____

I hereby verify I understand the office 'Cancellation Policy' requiring appointments to be cancelled at least **24 hours** prior to your scheduled session. If cancellation is not received, I authorize my credit card to be billed for the missed session. The authorization will remain in effect until it is revoked in writing. I certify that I am an authorized signer of the account provided.

_____

Name as it appears on card Signature Date

All credit card transactions will incur a service fee of 3.5%

PAYMENT INFORMATION

Self Pay

__ I do not currently have insurance coverage for mental health services (or do not wish to utilize my benefits) and will assume full responsibility for payment of services received at the time they are rendered.

INSURANCE INFORMATION

Primary Insurance: _____ Type: _____ (HMO, PPO, POS, etc)

Member ID#: _____ Group#: _____
Primary Insured Name: _____ DOB: _____
Relationship to client: _____
Provider information phone number _____

Secondary Insurance: _____ Type: _____ (HMO, PPO, POS, etc.)
Member ID#: _____ Group#: _____
Insured Name: _____ DOB: _____
Relationship to patient: _____
Provider information phone number _____

I hereby attest that I am, at the time of this appointment, an eligible member of the insurance carrier(s) listed above and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all deductible, coinsurance, and services not covered by insurance.

*****************PLEASE PROVIDE US WITH YOUR DRIVERS LICENSE & INSURANCE ID CARD******************

POLICY AND PROCEDURES

Consent for Treatment, Authorization for Payment, Cancellation Policy, HIPPA,
Outpatient Services Contract

I hereby apply for, and consent, to psychological evaluation and / or treatment by Helene Cohen Psy.D. LLC and associates and her affiliates for my child and/or for myself. I am aware that this consent may be withdrawn by me at any time.

Initial _____

I understand that it is my responsibility to cooperate with evaluation and or treatment to the best of my ability. I agree that I understand the limits of confidentiality as per Florida state law, Federal law and professional ethical standards. These standards provide for the limited confidentiality of psychotherapist/ client communications, including client records.

For example; your provider and this office will not disclose or confirm your use of services at this office without your consent. Lawful and legally required exceptions to this privilege of confidentiality include; information of child abuse, elder abuse, the immediate physical danger to yourself or another, a lawful court order or your signed consent.

Initial _____

I understand that insurance benefits, if any, will pay only for therapeutic sessions. Time spent on my behalf, or on behalf of my child, that involves telephone calls, preparation of letters or reports, psychological testing or attendance at schools, depositions, legal proceedings or other conferences are my financial responsibility and I will be responsible at the prevailing hourly rate for those services.

I authorize the payment of health benefits to which I am entitled, directly to Helene Cohen Psy.D. LLC and I acknowledge that I am responsible for all charges not covered by my carrier.

Initial_____

I understand that payment in full, or co-payments where applicable, are due **at the time services are rendered**, or as provided by state/federal statute or regulation. Also, should this account be sent to an outside agency for collection of a balance due, I am aware that I will be responsible for all and any fees assessed.

Initial _____

A copy of the HIPAA Notice of Privacy Practices has been made available to me.

Initial _____

My signature below indicates that I have read and agree to all policies.

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION

Client Name:_____ Telephone ( )_____

DOB:_____ SSN:_____

Authorizations for Dr. Schwartz-Cohen and her associates/staff to use, disclose, and/or exchange my protected health information to:

Person/Organization: _____Phone ( )_____

Address:_____ Fax ( )_____

Information Requested:_____

Purpose: _____

Person/Organization: _____Phone ( )_____

Address:_____ Fax ( )_____

Information Requested:_____

Purpose: _____

I may revoke this consent at anytime by notifying IN WRITING, except to the extent that the provider has taken action and reliance on this consent. Once the uses and disclosure have been made pursuant to this authorization, they may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws. Dr. Schwartz-Cohen or her associates will not condition treatment or payment on my providing authorization for this use or disclosure except to the extent provision of health care is solely for the purpose of creating protected health care information for disclosure to a third party on provision of an authorization for disclosure to such a third party.

I understand that I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand I may refuse to sign the authorization. I understand that if use or disclosure or the requested information will result in direct or indirect remuneration to the provider from a third party, a statement referencing such remuneration will exist in this authorization.

I understand that I may receive a copy of this authorization, upon request.

Signature: _____ Date _____

Signature of Personal Representative of the patient _____

Description of Representatives Authority to act on behalf of the patient _____

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OUTPATIENT SERVICES CONTRACT

Welcome to our practice. This document contains important information about my professional services and business policies. Please read it carefully. 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 outside of them.

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; however, there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and provide 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 evaluation that will last approximately 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 treatment goals. If psychotherapy is begun, I will usually schedule one 45 minute session (one appointment hour of 45 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, **you will need to cancel a minimum of 24 hours prior to your appointment to avoid payment of a full session fee.**

_____ _____

Signature **Date**

Please be advised that insurance companies will not pay for missed sessions. If your insurance company normally pays for your services, you – not your insurance company – will be billed in full for any session cancelled without adequate notice.

PROFESSIONAL FEES

Our standard rate for services is $250.00 per 45-50 minute session. In circumstances of unusual financial hardship, we may be willing to negotiate a reduced fee. In addition to weekly appointments, we charge the agreed upon fee for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. **Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.** If you become involved in **legal proceedings** that require my participation, you will be expected to pay for our professional time even if we are called to testify by another party. Because of the difficulty of legal involvement, we charge $350 per hour for preparation and attendance at any legal proceeding.

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 which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. For self-pay clients, in circumstances of unusual financial hardship, we may be willing to negotiate a reduced fee and/or payment installment plan.

If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, we 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 we 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 health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; **however, you (not your insurance company) are responsible for full payment of our fees**. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, please contact your plan administrator. We will provide you with whatever information we can based on our 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, we 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 health coverage is available. "Managed Health Care" plans such as HMOs and PPO's often require authorization before they provide reimbursement for mental 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, we 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. We 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 our services yourself to avoid the problems described above.

CONTACTING US

We are often not immediately available by telephone. When we are unavailable, our telephones are answered by voicemail that we monitor Monday through Friday 9-5pm. We 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 us and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. In addition, you may call mobile crisis at (954) 463-0911. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS

The laws and standards of my profession require that we keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, we recommend that you review them in our presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests, copying, and/or summary preparation.

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, we will provide them only with general information about our work together, unless we feel there is a high risk that you will seriously harm yourself or someone else. In this case, we will notify them of my concern. We will also provide them with a summary of your treatment when it is complete. Before giving them any information, we will discuss the matter with you, if possible, and do my best to handle any objections you may have with what we are prepared to discuss.

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. However, 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.

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, elderly person or disabled person is being abused, I must file a report with the appropriate state agency.

If we believe that a patient is threatening serious bodily harm to another, we are 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, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

We may occasionally find it helpful to consult other professionals about a case. During a consultation, we will 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, we will not tell you about these consultations unless we feel that it is important to our work together.

During couples' therapy, you and/or your partner may find it beneficial to have some individual sessions. What is said during those sessions will be considered part of the couples' therapy and may be discussed during our joint sessions.

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. We 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, we recommend you seek the counsel of an attorney.

OTHER RIGHTS AND RESPONSIBILITIES

You have the right to ask questions about anything that happens in therapy. We are open to discussing my decision making with regard to your treatment. In addition, we are open to considering any alternative treatments you think will be helpful to your care.

During the course of treatment, we may suggest that you consult with a physical health care professional regarding somatic treatments that could help with your problems. We refer to both traditional and non-traditional practitioners, and will be glad to discuss the alternatives with you. In cases where you are receiving treatment with another professional, we will request a release of information so that we may speak with this practitioner in an effort to provide you with continuity of care. You have the right to refuse anything that we suggest.

You have the right to terminate services at any time for any reason. If at any time you decide that your therapist is not the right therapist for you, we can/will refer you to someone else. If for any reason you are unhappy with your treatment, we ask that you discuss this with us so that we may have an opportunity to address your complaints. If you believe we have behaved unethically, you may file a complaint with the Board of Psychology, Department of Health, Tallahassee, Florida.

My signature below indicates that I have read and agree to all policies and procedures.

Signature: _____ Date: _____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) 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.

Uses and Disclosures of Protected Health Information:
Your PHI may be used and disclosed by your provider, 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, to pay your health care bills, to support the operation of the provider's practice, and any other use required by law.

Treatment:
We will use and disclose your PHI 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. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you.

Payment:
Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as needed, your PHI in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school or graduate students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose PHI, as necessary to contact you to remind you of your appointment.
We may use or disclose your PHI in the following situations without your authorization. These situations include: as required by law, public health issues as required by law; communicable diseases; health oversight, abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroners, funeral directors, and organ donation; research; criminal activity, military activity and National Security; Workers' Compensation; inmates 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.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.
You may revoke this authorization at any time, in writing, except to the extent that your provider or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information. (PHI)

You have the right to inspect and copy your protected health information. 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 PHI that is subject to law that prohibits access to PHI.

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 PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI 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 written request must state the specific restriction requested and to whom you want the restriction to apply.
Your provider is not required to agree to a restriction that you may request. If the provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communications from us by alternative means or at an alternate location.

You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

You may have the right to have your provider amend your protected health information. 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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.**

This notice was published and becomes effective on/or before **April 14. 2003.** We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

ELECTRONIC COMMUNICATION POLICY

In order to maintain clarity regarding our use of electronic communication during your treatment, Helene Cohen, Psy.D. & Associates has prepared the following policy.

Various types of electronic communication are common in our society, yet while many people prefer this mode of contact with others for either social or professional purposes, it may put your privacy at risk. Moreover, such communication can be inconsistent with the law and with the standards of our profession. Consequently, this policy has been prepared to ensure the security and confidentiality of your treatment and to assure its consistency with ethics and the law. If you have any questions about this policy, please feel free to discuss them with your therapist.

Email Communications

We use email communication only with your permission, and only for administrative purposes, unless we have made another agreement. As such, email exchanges with our office should be limited to setting and changing appointments, coordinating billing, and other related issues. As email is not a secure method of contact, we ask that you do not email your therapist about clinical matters. If you need to discuss a clinical matter with your therapist, please feel free to call them during your next therapy session or wait to discuss it. Communicating either by phone or face-to-face is more secure.

I Authorize Email Communications (Initial)_____

Text Messaging

Text messaging is an unsecured and impersonal mode of communication. We neither send nor respond to text messages to or from clients, unless we have made another agreement, or unless you have consented to (i.e. appointment reminders). As such, we ask that you please do not communicate via text message about clinical matters, unless alternate arrangements have been made.

I Authorize Text Message Communications (Initial)_____

Social Media

We do not communicate with any clients through social media platforms such as Twitter or Facebook. If we discover that we have accidentally established an online relationship with you, the connection will immediately be removed.

Although we may participate on various social networks, it is not in our professional capacity. If you have an online presence, there is a possibility that you may encounter your therapist unintentionally. If so, please discuss it with him/her during your next session. We believe that any communication with clients online has the potential to compromise the professional relationship. Please do not try to contact your therapist via social networks, as we are unable to respond and will not engage in online communication.

Websites

Helene Cohen, Psy.D. & Associates has a website that provides information about our practice and professional services. You are welcome to access and review the information on the website and discuss any questions during your therapy sessions.

Web Searches

Your therapist will not use web searches to gather information about you without your permission. We believe that this violates your right to privacy. Nevertheless, we understand that you may wish to gather information about your therapist in this way.

An incredible amount of personal information is widely available on the internet, including that which is provided with an individual's knowledge and consent, as well as information that may be inaccurate or unknown. If you encounter any information about your therapist through web searches, or in any other manner, please discuss it with him or her during your session. This will allow you and your therapist to maintain an open dialogue, and for any potential impact on your treatment to be considered.

Recently, it has become common for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to comments or related errors because of confidentiality restrictions. If you encounter such reviews of any professional with whom you are working, please discuss this with your therapist so any potential impact on your therapy can be discussed. Please do not rate your therapist's work with you while in treatment on any of these websites, as it may damage the ability for you and your therapist to work together.

_____ _____

Signature of Patient/Guardian Date