Dear New Patient:

Enclosed please find the following documents:

New Patient Information Sheet
Psychotherapy Questionnaire
Authorization Form
Acknowledgement of New Jersey Notice Form

Please complete the packet and bring it with you to your first appointment. Please read the Fees and Payment Policies carefully. If your treatment is not covered by insurance, the $175 per session fee will be collected at the time services are rendered and may be paid by check (written out to Adinah Liss-Bialik) or by credit card authorization.

If you have any questions, or need assistance completing this packet, please do not hesitate to call my office. Thank you for allowing us to participate in your care.

Sincerely,
Adinah Liss-Bialik, Ph.D.

Adinah Liss-Bialik, Ph.D.
16 Bank Street
Morristown, NJ 07960
973.975.0280

Psychotherapy

New Patient Information Sheet Page 1 of 4

Name: _____

Date of Birth: _____ Age: _____ Gender: _____ SSN: _____

Home Address: _____

_____

Phone Number: _____

Email Address: _____

Is it OK for the doctor or a staff member to leave messages at those numbers?

Please specify: _____

Contact Name (if Different than Patient): _____

Address: _____

_____

Phone Number: _____

Referring Physician (Name and Specialty), if applicable: _____

_____

Address: _____

Phone Number: _____ Fax Number: _____

Do you want the doctor to communicate with this physician? _____

If so, please complete the Authorization Form.

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Insurance Information

Primary Insurance Carrier: _____

Policy Number: _____

Secondary Insurance

Secondary Insurance Carrier: _____

Policy Number: _____

Please provide copies of your insurance cards (front and back) or bring them to the first scheduled appointment so that we may make copies.

Insurance Authorization and Release:

If your treatment is covered by your insurance carrier, will bill the insurance carrier on your behalf. In order for us to do so, you must sign the authorization below:

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to Adinah Liss Bialik, Ph.D. for services provided.

_____

Signature of Patient or Legal Guardian

_____

Print Name of Patient or Legal Guardian

_____

Date

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Please read the Fees and Payment Policies agreement carefully and contact the office with any questions before signing. If your insurance carrier requires a copay, we will collect the copay on the dates of sessions payable by cash, check, or credit card. If your insurance carrier does not cover treatment, the cost of an individual psychotherapy session is $175 payable by a check written out to Adinah Liss-Bialik or provide credit card information below.

___ check enclosed or will be provided at the appointment based on fee structure outlined in the Fees and Payment Policies Agreement.

___ I authorize Adinah Liss-Bialik and Be Well. Morristown. to charge the credit card below for any unpaid balances for services rendered. Charges will be consistent with the fee structure outlined in the Fees and Payment Policies Agreement. This authorization will remain in effect until terminated by me in writing.

Card Type: _____Visa ____Mastercard ____American Express _____Discover

Card Number: _____

Expiration Date: _____

3-Digit Security Code (on back of card): _____

Payment Method/Credit Card Authorization:

Card Holder Name and contact information (if different than patient):

First Name: _____

Last Name: _____

Billing address (please include city, state and zip code):_____

_____

Phone Number: _____

Email Address: _____

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FEES AND PAYMENT POLICIES

Adinah Liss-Bialik, Ph.D. bills $175 per 55 minute session. A 48 hour cancellation policy is strictly enforced; without 48-hour notice, patients are responsible for paying for the session.

Your insurance carrier may cover the cost of sessions. Since many plans include out of network benefits for psychotherapy sessions, the patient is encouraged to learn about the relevant policies of his/her health insurance plan that may make reimbursement possible.

If Adinah Liss-Bialik is a provider for a patient's health insurance carrier, Adinah Liss-Bialik will bill the insurance carrier for the services rendered. It is the patient's responsibility to be knowledgeable of his/her benefits. The patient is responsible for payment not made by insurance.

If Adinah Liss-Bialik is not a provider for a patient's health insurance carried, payment is expected at the time services are rendered. It is the patient's responsibility to pay Adinah Liss-Bialik (a check written out to Adinah Liss-Bialik in the amount of $175 per session or authorization to charge a credit card) and seek reimbursement from their insurance carrier independently if s/he wishes to do so. Be Well. will provide an invoice to each patient containing all necessary information for claim submission (e.g., procedure codes, diagnosis codes, identifying information). If you plan to contact your insurance company before the evaluation to find out about possible reimbursement, the procedure code used is usually 90837

I have read the above statements regarding fees and payment policies and agree to these terms.

_____
Signature of Patient or Legal Guardian

_____
Print Name of Patient or Legal Guardian

_____
Date

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Psychotherapy Self-Report Questionnaire

Patient Name: _____

Date of first appointment: _____

Marital Status: _____

Number of Children: _____

Reason for Appointment: _____

_____

_____

_____

Please list any past or present medical conditions: _____

_____

_____

Please describe relevant psychological history: _____

_____

Are you currently in treatment with a psychiatrist? _____

If so, please describe current medications, including dose, prescribing physician and duration of treatment: _____

_____

Past medications to treat psychological problems: _____

_____

_____

Please list any other medications that you are currently taking, along with dose, duration, and purpose: _____

_____

_____

Is there any additional information that you would like to add?_____

_____

_____

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Authorization Form Page 1 of 2

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize Adinah Liss-Bialik to release: _____
_____
_____
(Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.)

This information should only be released to: _____
_____
_____
(Provide the name and address of person to whom the information is to be released.)

I am requesting my psychologist to release this information for the following reasons:
_____
_____
_____
("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

This authorization shall remain in effect until _____(fill in expiration date) or until _____(fill in an event that relates to the individual or the purpose of the use or disclosure).

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You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I am aware of my right to confidential communications under psychologist-patient privilege.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

If authorizing the use or disclosure of psychotherapy notes, I understand that such authorization cannot be required as a condition of treatment, payment, enrollment, or eligibility for benefits.

_____

Signature of Patient

_____

Print Name

_____

Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided

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Acknowledgment of Notice

I have reviewed and been offered written notice of psychologists' policies and practices with regard to the HIPAA Privacy Act. I understand and agree to the contents of this Notice. I also understand that I may contact Adinah Liss-Bialik should I have questions regarding my rights as a patient of this provider.

Signature _____

Print name _____

Date _____

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Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

"*PHI"* refers to information in your health record that could identify you.

"*Treatment"* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

"*Payment"* is when I may assist you in obtaining reimbursement for your healthcare. Examples of payment are if I disclose your PHI to your health insurer to help you obtain reimbursement for your health care or to determine eligibility or coverage.

"Health Care Operations" are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

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"*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If I have reasonable cause to believe that a child has been subject to abuse, I must report this immediately to the New Jersey Division of Youth and Family Services.

- Adult and Domestic Abuse: If I reasonably believe that a vulnerable adult is the subject of abuse, neglect, or exploitation, I may report the information to the county adult protective services provider.

- Health Oversight: If the New Jersey State Board of Psychological Examiners issues a subpoena, I may be compelled to testify before the Board and produce your relevant records and papers.

- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I must inform you in advance if this is the case.

- Serious Threat to Health or Safety: If you communicate to me a threat of imminent serious physical violence against a readily identifiable victim or yourself or the public and I believe you intend to carry out that threat, I must take steps to warn and protect. I also must take such steps if I believe you intend to carry out such violence, even if you have not made a specific verbal threat. The steps I take to warn and protect may include arranging for you to be admitted to a psychiatric unit of a hospital or other health care facility, advising the police of your threat and the identity of the intended victim, warning the intended victim or his or her parents if the intended victim is under 18, and warning your parents if you are under 18.

- Worker's Compensation: If you file a worker's compensation claim, I may be required to release relevant information from your mental health records to a participant in the worker's compensation case, a reinsurer, the health care provider, medical and non-medical experts in connection with the case, the Division of Worker's Compensation, or the Compensation Rating and Inspection Bureau.

There may be additional disclosures of PHI that I am required or permitted by law to make without your consent or authorization, however the disclosures listed above are the most common.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologists' Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will notify you at the time of your next visit.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Be Well. Morristown.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to Be Well. Morristown 16 Bank Street Morristown, NJ 07960.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date

This notice will go into effect on January 1, 2016.

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