Jennifer Piede, MSEd, LPCC, NCC
jenniferpiedecounseling@gmail.com
www.jenniferpiedecounseling.com
(585) 315-9240

PERSONAL DATA RECORD

Client Name: _____ Date of Birth _____

Address: _____

City/State/**Zip**: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other Phone: _____

SSN: _____ TXDL: _____

Employer/School: _____

Referred to Our Office by: _____

INSURANCE INFORMATION

Insured Name: _____ Date of Birth: _____

Relationship to Client _____

Insured's Employer _____

Insured's SSN _____ Insurance Co. _____

Policy No.: _____ Group No. _____

Insurance Co. Address: _____

Insurance Co. Phone _____

If you would like us to auto-charge your credit card for your fee or copayment, please complete the authorization information below:

Credit Card # _____ Exp. Date _____

Name as Listed on Card: _____

Signature of Authorized User: _____

CVV _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address/Phone: _____

FINANCIAL RESPONSIBILITY

Name of person(s) financially responsible for this account: _____

Address(es): _____

Signature(s): _____

Relationship(s) to client: _____

Jennifer Piede, MSEd, LPCC, NCC
jenniferpiedecounseling@gmail.com
www.jenniferpiedecounseling.com
(585) 315-9240

Consent for Treatment

Client Name: _____ Birthdate:_____

I give full consent for myself or my child/adolescent to receive outpatient mental health services until I notify Jennifer Piede of any changes or until it is determined that treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for myself or my child/adolescent.

_____ _____
Authorized Signature Date

Authorization to Pay Benefits

I request that payment of authorized insurance benefits be made on my behalf to Jennifer Piede Mental Health Counseling, LLC for professional services rendered to me or my dependent. The undersigned is financially responsible for fees not paid pursuant to this agreement. I authorize any holder release of medical information as may be required for the completion of my claims. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of client: _____

Signature of insured: _____

Date: _____

Jennifer Piede, MSEd, LPCC, NCC
jenniferpiedecounseling@gmail.com
www.jenniferpiedecounseling.com
(585) 315-9240

OFFICE POLICIES

PAYMENT FOR SERVICES: Clients are expected to pay for services at the time they are rendered unless other arrangements have been made. Please notify us if any problem arises during the course of your therapy regarding your ability to make timely payment. Failure to keep your account current may result in legal or collection agency intervention, which could adversely affect your credit rating. A fee of $25 will be assessed for returned checks.

INSURANCE REIMBURSEMENT: Your health insurance policy is a contract between you and your insurance company. I am not a party to that contract. Although I am not listed as a provider on many network panels, benefits are often available for services rendered by "out-of-network" providers. I advise that you contact a company representative to determine how your insurance company will reimburse you. If you elect to seek reimbursement by an insurance carrier for services rendered, I will provide you with a receipt to assist you in completing your insurance claim. I will consult your third-party payer only at your direction with such consultations billed to your account. Some insurance companies reimburse clients for services, and some do not. Those that do, usually require "a standard amount be paid by you" before reimbursement is allowed, and then usually a percentage of the fee is reimbursable. The client remains responsible for payment in full, including any portion not reimbursed by insurance. **Please be aware that: Third-party payers require the provision of a diagnosis and supporting clinical data. We have no control over the confidentiality procedure of third parties once clinical information leaves this office. In all likelihood, a computer record will be generated.** Since I do not contract directly with many insurance companies, I am responsible and accountable only to you. Thus my loyalties are not divided, and there is no conflict of interest. I am happy to provide you with insurance ready receipts for filing your claim. I do not file out-of-network insurance claims.

CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for rescheduling or cancellation of an appointment. The fee of $25 will be charged for missed sessions without such notification.

CONFIDENTIALITY: All information disclosed within sessions is confidential and may not be revealed to anyone without written permission except where disclosure is required by law. Disclosure may be required in the circumstances where there is reasonable suspicion of child or elder abuse and where there is reasonable suspicion that the client is likely to harm himself/herself unless protective measures are taken. Disclosure may also be required pursuant to a legal proceeding.

AFTER HOURS EMERGENCY PROCEDURE: It is assumed that outpatient clients are self-responsible, autonomous, and not in need of day-to-day supervision. Outpatient clinicians cannot assume responsibilities for clients' day-to-day functioning, as can agencies our inpatient hospital settings. Nevertheless, in the event that an emergency occurs, leave a message with my voicemail, making sure to state that your call is an emergency. I will respond to your call as promptly as possible. Routine calls will be returned during normal office hours. If we are unable to respond quickly enough, please call 911 or your local emergency room.

We respectfully request that **CELL PHONES** be turned off during your sessions.

Jennifer Piede, MSEd, LPCC, NCC
jenniferpiedecounseling@gmail.com
www.jenniferpiedecounseling.com
(585) 315-9240

Managed Health Care plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. Under these plans, it may be necessary to seek approval for more sessions periodically. You should also be aware that contracts with health insurance companies generally require that we provide them with information relevant to the services you are being provided. We are usually required to provide a clinical diagnosis. Sometimes, additional clinical information such as treatment plans or summaries is also required. In such situations, we make every effort to release only the minimum information about you that is necessary for the purpose requested. 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 its use. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above.

*****PRIVATE-PAY CLIENTS PLEASE NOTE!!!! It is advisable for you to contact your carrier to verify the network status of your therapist before your first appointment! If at a later date it is determined that your therapist is indeed a participating provider on your policy and you have not provided our office with sufficient carrier identification information; you will not be refunded the difference between our normal fees and any reduced contracted fees that may apply to your policy!!!*****

Confidentiality: The law protects the privacy of all communications between a client and psychotherapist. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by federal and state law. There are other situations that require only that you provide written, advance general consent. Your signature on our Acknowledgment form provides consent for those activities, as follows:

You should be aware that we practice with other mental health professionals and utilize administrative staff. In most cases, some protected information must be shared with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. Occasionally, it is helpful to consult other health and mental health professionals about a client. During a consultation, every effort is made to avoid revealing a client's identity. Any other professionals consulted are also legally bound to keep the information confidential. These consultations are very commonplace and routine and may not ordinarily be mentioned in our sessions unless it seems important to our work together. If you would prefer to handle this differently, please let us know. All administrative staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

We also have contracts with some business services, such as the answering service, electronic claims processing services, and managed care organizations. As required by federal law, we have formal business associate contracts with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. Details of these contracts are available on request.

Jennifer Piede, MSEd, LPCC, NCC
jenniferpiedecounseling@gmail.com
www.jenniferpiedecounseling.com
(585) 315-9240

Notice of 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

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

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  Treatment is when we 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 a colleague.
  Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to 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.
- "*Use*" applies only to activities within WFI such as utilizing information that identifies you.
- "*Disclosure*" applies to activities outside of WFI, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We 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 we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes we have made about our conversation regarding a private, group, joint, or family counseling session. 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) we 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

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

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Ohio Department of Youth Services, Ohio Department of Child Protective Services, or to any local or state law enforcement agency.
- **Abuse of the Elderly and Disabled:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Ohio Department of Public Safety.
- **Regulatory Oversight:** If a complaint is filed against a therapist with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to that complaint.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case**.**
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Client's Rights and Our Professional Duties

Client'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, we are 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 seeking our services. Upon your request, we will send bills or other correspondence to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we 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. We may deny your request. On your request, we 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, we 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.

Our Professional Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post a current copy in our offices. A current copy will always be available on our web site and you may request a personal copy.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Jennifer Piede at 585-315-9240.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Jennifer Piede at: 5040 Forest Drive, Suite 210, New Albany, OH 43054.

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. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on 4/14/2003. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. You may request a personal copy at any time.

Jennifer Piede, MSEd, LPCC, NCC
jenniferpiedecounseling@gmail.com
www.jenniferpiedecounseling.com
(585) 315-9240

Please indicate below how we may contact you and whether we can leave a message:

☐ Home Phone May we leave a message (Circle One)? Yes No

☐ Work Phone May we leave a message (Circle One)? Yes No

☐ Cell Phone May we leave a message (Circle One)? Yes No

☐ Unencrypted (normal) email (address): _____

If you would like us to use an address other than your home address for billing and other correspondence, please provide an alternative address below.

Other (Specify) _____

You may change the above instructions at any time by requesting another one of these forms or otherwise instructing us in writing.

ACKNOWLEDGEMENT

I have been provided a copy of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information** and the **Office Information and Office Policies**. I understand and accept those policies and practices. Jennifer Piede, MSEd, LPCC, NCC is hereby granted consent to contact me as specified above, and for the use and disclosure of my health information as described in those policies for Treatment, Payment and Health Care Operations.

_____

Client or Authorized Representative Signature Date

☐ Refused to Sign

☐ Unable to Sign (Specify Reason) _____

_____

Signature of Person Documenting Refusal or Inability to Sign Date