INITIAL CONSULTATION PACKET

Updated: *September 5, 2023*

Thank you for downloading this document. This is intended to orient you to the ways my practice is organized and to inform you of the ways I may or may not be able to address your needs in seeking psychotherapy.

In advance of your appointment, please complete and return the Basic Information Form.

While you may wait to sign the other sections pending a mutual decision to work together, please read those sections and note any questions you may wish to discuss during your appointment.

Geoffrey Steinberg, Psy.D.
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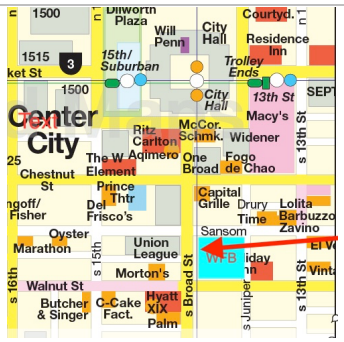
(215) 410-7024

Pennsylvania License PS018259
New York License 016942

Contents

Wayfinding to the Office



123 South Broad Street
(The Wells Fargo Building)
Suite 2540
Philadelphia, PA 19109

located between Sansom & Walnut Streets

Enter through the northernmost arch, near the corner of Sansom Street.

This entrance is 123 South Broad.

Check in with security personnel. You may be asked to show your ID and to sign a visitor registry. Simply say the name of the doctor you are visiting.

If asked for the name of the company you are visiting, answer "Broadminded." This is how we are listed in the directory at the desk.

To the right of the front desk is the bank of elevators for the 16th to 28th floors.

Take the elevator to the 25th floor.

Leaving the elevator, walk to the hallway and take a right.

Enter Suite 2540.

Please have a seat in the waiting room.

We ask that you please silence your cellphone and refrain from bringing food into the waiting room.

Basic Information Form

Contact Information

First Name			
Last Name			
Street Address			
City	State	ZIP	OK to send mail? ☐ Yes ☐ No
Email			OK to Email? ☐ Yes ☐ No

	OK to call you?	OK to leave message?
Home Phone	☐ Yes ☐ No	☐ Yes ☐ No
Cellular Phone	☐ Yes ☐ No	☐ Yes ☐ No
Work Phone	☐ Yes ☐ No	☐ Yes ☐ No

Demographics

Date of Birth	Current Age
Gender Identity	
Sexual Identity	
Marital/Partner Status	
Ethnic/Cultural Identities	
Education	
Employer	
Occupation	

Emergency Contact

First & Last Name
Street Address
City, State ZIP
Phone
Relationship to you

Family

Country of birth		
Years in US		
Is your father alive?	☐ Yes ☐ No	Father's age: _____
Is your mother alive?	☐ Yes ☐ No	Mother's age:_____
Parents' marital status	☐ Divorced ☐ Married ☐ Partnered ☐ Separated ☐ Never Married ☐ Widowed	
Number of siblings		
Your position in birth order		
Are you a parent?	☐ Yes ☐ No If you have children, what are their ages?	
Your religion in childhood		
Your religion now		

Insurance

Do you have health insurance?	☐ Yes ☐ No
Insurance Carrier:	
Type of plan:	☐ HMO ☐ PPO ☐ POS
Insurance ID:	
Are you the primary person insured by your policy?	☐ Yes ☐ No If no, please provide the primary insured's information:
What is your relationship to the primary insured?	☐ Spouse ☐ Child ☐ Other:_____
Name	
Date of birth	
Street Address	
City, State ZIP	

Health

Overall, how is your health?	☐ Excellent ☐ Good ☐ Fair ☐ Poor
Current health concerns:	
Have you had any serious illness or injuries?	☐ Yes ☐ No If yes, describe:
When did you receive your most recent Covid-19 vaccine?	
Have you ever tested positive for Covid-19?	☐ Yes ☐ No If yes, are you continuing to experience any residual symptoms? :
Do you have a disability?	☐ Yes ☐ No If yes, describe:
Physician's Name	
Physician Phone	
Are you under the care of a psychiatrist?	☐ Yes ☐ No
Psychiatrist Name	
Psychiatrist Phone	
Have you ever been hospitalized?	☐ Yes ☐ No If yes, describe:
Are you currently taking any medications?	☐ Yes ☐ No If yes, list each medication's name, amount, and frequency:

Selected Symptoms & Concerns

Please check all that apply:	*Past*	*Current*	*Notes*
Concerns about eating patterns	☐	☐	
Sleep problems	☐	☐	
Alcohol abuse	☐	☐	
Substance abuse	☐	☐	
Sexual concerns	☐	☐	
Depression	☐	☐	
Self-Injurious behavior	☐	☐	
Suicidal thoughts	☐	☐	
Suicide attempt	☐	☐	
Physical aggression	☐	☐	
Abusive relationship	☐	☐	
Anxiety	☐	☐	
Panic attacks	☐	☐	
Obsessions or compulsions	☐	☐	
Exposure to traumatic events	☐	☐	
Attention/concentration problems	☐	☐	

Legal

Have you in the past been involved in any type of litigation?	☐ Yes ☐ No If yes, please describe.
Are you currently involved in any type of litigation?	☐ Yes ☐ No If yes, please describe.
Do you expect in the near future to become involved in any type of litigation?	☐ Yes ☐ No If yes, please describe.

Prior Psychotherapy

Have you ever been in psychotherapy before? ☐ Yes ☐ No

If Yes, when and with whom?

What was helpful about your past therapy?

What was not helpful?

Referral

Why are you seeking psychological services at this time?

How did you hear about my practice?

Outpatient Services Agreement

updated September 5, 2023

Welcome to my practice. This document contains important information about my professional services and policies. Please read it carefully and note any questions you may have so that you and I can discuss them at our next meeting. Once you sign this, it will constitute a binding agreement between us.

Psychological Services

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 initial impressions of what our work may include if you and I decide to work together. You should evaluate this information along with your own assessment about whether you feel comfortable working with me.

Psychotherapy involves a significant commitment of time, money, and energy, so you should be careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise.

Psychotherapy requires an active effort on your part, specifically to observe yourself, to reflect on your experiences, to express your reactions to the therapy process, and eventually to use what you have learned about yourself to begin making changes in how you relate to others.

Psychotherapy has both benefits and risks. It has been shown to have benefits for people who undertake it, including reduction in feelings of distress, better quality of relationships, and resolutions of specific problems. However, there are no guarantees about what will happen. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness. It is not unusual to feel worse before feeling better.

Contacting Me

Though I am not usually available by phone, I routinely check both voicemail and email during regular business hours. Text messages are not a secure mode of communication. My telephone is a landline in the office, so no text messages will be received.

I do not routinely check voicemail messages after regular business hours. If you need to speak with someone immediately, crisis counseling is available by telephone 24 hours a day in Philadelphia by calling the Office of Behavioral Health Emergency/Information Line at 215-685-6440. In New York, call NYC Well at 888-692-9355. If you experience a life-threatening emergency, call 911 or go to the nearest hospital emergency room and request to be seen by a mental health professional.

I will inform you of my planned vacations and holiday absences several weeks in advance. These dates are regularly posted at drgeoffreysteinberg.com/calendar/

I am not typically available for telephone or email consultations outside of scheduled appointments. Should the need arise, you are welcome to contact me to schedule an additional appointment at a mutually agreeable time. However, if you anticipate the need for routine contact between scheduled appointments, I may be able to help you find a referral to another professional whose practice includes such a provision.

Cancellation Policy

If you and I decide to work together, I will usually schedule one forty-five-minute session per week at a mutually agreed time. Once this appointment hour is scheduled, you will be expected to pay for it. For clients with weekly appointments, four free absences are allowed per year. You are responsible for payment of any additional absences beyond those allowed, regardless of the reason or type of absence. These include absences of all types, including illness, advance cancellations, late cancellations, and no- shows. Holidays and other days the office is closed will not count as absences.

The allowance of free four absences per year will be issued 30 days following the initial consultation. New clients will be responsible for payment for any absences that occur within the first 30 days.

I appreciate the courtesy of advance notice if you know that you will not be able to attend a scheduled appointment. However, regardless of whether you have provided such notice or not, you will be charged for missed appointments that exceed the allotted number of free absences.

In instances where your insurance company set limits upon the number of sessions covered per year, you will be responsible for payment of sessions that exceed such limitations.

You will be required to keep a credit card or check card on file and to provide signed authorization that this card may be charged for absences that exceed the allowance of free absences. You will be responsible for updating your credit card information whenever it may change.

Excessive cancellations should be avoided because keeping therapy appointments on a consistent basis is essential to making meaningful progress. In situations where a client shows a pattern of excessive cancellations and efforts to address the situations are unsuccessful, the client may lose their reserved appointment hour. Such situations are rare and are usually resolved successfully.

Please note that although the cancellation policy is described in terms of absences within the course of a year, you have the right to end therapy at any time—please see the Termination Policy.

Termination Policy

You and I both have the right to end our work together at any time.

If at any point I believe that our work together is no longer effective in helping you reach your therapeutic goals, I will discuss it with you and, if appropriate, I may decide to end our work together. In such a case, I would offer you referrals to other recommended professionals.

If at any point you are thinking about ending our working together, I would encourage you to talk with me about it, so we can reach a shared understanding of the reasons to stop therapy and an agreement about when to do so.

Once you and I have agreed to end psychotherapy, I recommend setting a date for our last session and using the remaining sessions to discuss the ending. Focusing together on the experience of termination can often be of value to review the course of work we have done together, to identify areas that you may wish to continue to address on your own, and to talk about how it feels to end our working relationship.

Litigation Limitation Policy

I do not accept new clients into my practice who are currently engaged in a legal dispute or expect to become involved in one in the near future. It is agreed that should you become involved in legal proceedings (for example, divorce and custody disputes, injuries, criminal proceedings, lawsuits, etc.), neither you, nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of your records be requested.

In the rare circumstance that you become involved in litigation that requires my participation, you will be expected to pay for the professional time required, even if I am compelled to testify by another party.

Professional Fees

Out-of-Network

I work with many clients on an out-of-network basis. The only insurance company for which I am a participating provider is Aetna. With many insurance plans, you may be eligible for reimbursement of fees that you pay to an out-of-network psychologist. It is your responsibility to be aware of the specifics of your insurance policy, including pre-authorization, deductible, and annual session limits, as each of these factors may impact your ability to receive reimbursement.

My fee for individual therapy is $200 (45 minutes) or $225 (52 minutes). Payments are due at the time each session is held. I will then provide you a monthly statement that you may submit to your insurance company for partial reimbursement. To be eligible for reimbursement, this statement will include a diagnosis code, dates of treatment, and duration of each session.

These fees may increase periodically, no more than once per year. I will inform you in advance of any changes in fees.

In-Network

If you are insured by Aetna or Aetna Student Health, then you will be responsible for paying the deductible and co-pay amounts as specified by your insurance policy. Your signature on this document authorizes my practice to submit claims for your mental health care to Aetna.

Your insurance will not pay for sessions that were not held. Therefore, you will be responsible for paying for any sessions you have missed (beyond the number of free absences allowed per year). In such circumstances, your credit card on file will be billed at the per-session rate for which I am contracted with Aetna.

If your insurance policy sets a limit on the number of sessions that you may attend, you will be responsible for paying out-of-pocket at an agreed-upon rate for the remainder of the benefit year.

Billing and Payments

You will be expected to pay for each psychotherapy session at the time it is held, unless you and I agree otherwise. All clients are required to keep an active credit/debit card or checking account on file. You will be asked to authorize a credit/debit card or checking account for automated recurring billing which will occur on each date of service. Your card or account on file will also be charged in the event of any missed sessions that exceed the allowed number of free absences (see Cancellation Policy).

For Aetna-insured clients (i.e., in-network), your policy determines the deductible and co-insurance (percentage) or co-payment (fixed amount) for which you are responsible. This amount will be billed to your card or bank account on file on the day of service.

Additional Fees

A fee of $25 will be charged for a declined credit card transaction or returned check, and a pattern of such declined transactions may result in the requirement of payment by money order.

In addition to weekly appointments, it is my practice to charge my standard fee on a prorated basis for other professional services you may require, such as report writing or consultations with other professionals that you have authorized. Payment schedules for other professional services will be agreed upon at the time these services are requested.

In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or installment payment plan. If your account is more than 60 days in arrears and suitable arrangements for payment have not been made, I have the option of using legal means to secure payment, including collection agencies. In such cases, the only information I would release about a client's treatment would be the client's name, the kind of professional services, and the amount due.

Case Management Policy

I run my practice in as independent and private a manner as possible by choosing not to be contracted with insurance companies that are likely to impose excessive bureaucratic requirements. Even on an out-of-network basis, some insurance companies may request additional information about your treatment in the form of utilization reviews or requests for additional information about you.

My default response is to refuse such requests for the dual purpose of protecting your privacy and maintaining the autonomy of my practice. I will notify you if I have received any such requests from your insurance company, and you and I may discuss on a case-by-case basis whether or not to comply with such requests. Time spent on case management will be billed to your account on a prorated basis.

If you are insured by Aetna, your case may be selected by Aetna for a utilization review meeting by telephone. If your case is selected for utilization review, I will discuss this with you before participating in the review, and you and I may decide together whether or not to comply with the request. Time spent on utilization reviews with Aetna will not be charged.

If in addition to individual psychotherapy you are also being treated by a psychiatrist or another mental health professional (for example, group therapist, couple's therapist), with your written authorization I may periodically discuss your treatment with that professional to ensure continuity of care. There is no charge for routine coordination of care with other mental health or medical professionals. However, in the event you are hospitalized, your account will be billed for time spent on coordination of care with treatment providers at the hospital.

If you have authorized me to discuss your case with any other individuals who are not mental health professionals (for example, a family member or employer), time spent on these activities will be billed to your account on a prorated basis.

Privacy Policy (Summary)

The full text of this practice's privacy policy will be supplied to you separately from this agreement.

I am ethically bound to maintain the confidentiality of psychotherapy and evaluation services to you and of your written records. The only exceptions are in specific circumstances where you have authorized the release of information to another party or when reporting is mandated by law.

In general, law protects the confidentiality of all communications between a client and a psychologist, and I can only release information about you to others with your written authorization. However, there are a number of exceptions.

In most judicial proceedings, you have the right to prevent me from providing any information about your treatment. However, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require my testimony if he or she determines that resolution of the issues before him/her demands it.

There are some situations in which I am legally required to take action to protect others from harm, even though that requires revealing some information about a client's treatment. For example, if I believe that a child, an elderly person, or a disabled person is being neglected or abused, I am required to file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another person, I am required to take protective actions, which may include notifying the potential victim, notifying the police, and/or seeking appropriate hospitalization. If a client threatens to harm him/herself, I may be required to seek hospitalization for the client, and/or to contact family members or others who can help provide protection.

I may occasionally find it helpful to consult about a case with a colleague. In such consultations, I make every effort to avoid revealing the identity of my client. The consultant is also a licensed psychologist who is also legally bound to maintain confidentiality of protected health information. Unless you object, I will not tell you about these consultations unless I feel that it is important to our work together.

The laws governing these issues are complex, and I am not an attorney. While I am happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable. If you request, I will provide you with relevant portions or summaries of the applicable state laws governing these issues.

Professional Records

Both law and the standards of my profession require that I keep appropriate treatment records. You are entitled to receive a copy of the records at your written request, unless I believe that seeing them would be emotionally harmful to you. Because these are professional records written in technical language, they can be misinterpreted or can be upsetting, so if you request your records, then I recommend that you and I review them together to discuss what they contain.

The Federal Health Insurance Portability and Accountability Act (HIPAA) does not provide a patient the same right of access to psychotherapy notes as to other parts of a medical record, so even if I have granted a request to provide you a copy of other portions of your treatment record, under no circumstances will psychotherapy notes be provided.

Covid-19 Prevention in the Office & Telehealth Considerations

I am operating on a hybrid model of in-person and video Telehealth appointments. During times of high rates of local transmission, in-person appointments may revert to Telehealth.

If you are scheduled to meet in the office, please ask yourself the following questions:

- Have I been exposed to anyone with Covid in the last ten days?
- Do I have any symptoms of Covid?
- Have I been in close contact with anyone with Covid symptoms?

If you or I answer yes to any of the above questions, we will need to change your appointment to Telehealth.

Expectations & Agreements

- In-person appointments are not required. Telehealth will continue in many circumstances, including clients' personal preferences and when necessitated by safety considerations.
- While steps have been taken to reduce risk, meeting in person increases risk of exposure to Covid-19 compared to Telehealth. It is important to weigh clinical benefits of meeting in-person against the risk of exposure to Covid-19. You and I will discuss this risk/benefit ratio on an individual basis.
- Do not come into the office if you have tested positive for Covid-19 in the past two weeks, or if you recently had contact with a person who tested positive for Covid-19 in the past ten days.
- Do not come into the office if you have Covid-19 symptoms, such as fever, sore throat, coughing, new loss of taste or smell, nausea or vomiting.
- In accordance with current city guidelines, masks are not required, but are suggested as a courtesy in the building and in our waiting room.
- Masks are not required in the consulting room during your appointment.
- Eating, drinking, and phone conversations are not permitted in the waiting room.
- Please arrive shortly before your appointment and leave quickly afterwards.
- This guidance is expected to change over time in accordance with public health recommendations.

Preventive Measures in the Office

- All clinicians working in the Philadelphia office have been fully vaccinated and boosted.
- All clients have reported full vaccination status.
- Gaps are scheduled between appointments to reduce exposure between clients.
- Air purifiers by Molekule operate continuously in both the waiting room and the consulting room. According to the manufacturer, Molekule Air Mini and Air Mini+ purifiers are "FDA-cleared for medical use"and "satisfy performance criteria outlined in FDA guidance for use in helping to reduce potential exposure to SARS-CoV-2, the COVID-19 virus."

Continuous Updates to Prevention Plan

Updates to our prevention strategies are communicated verbally, by email, and through updates posted to drgeoffreysteinberg.com/reentry/

Video Telehealth/Telepsychology Checklist

You'll find my Telehealth portal at https://doxy.me/geoffreysteinbergpsyd
I'll provide you a password prior to your appointment.

Prior to starting Telepsychology services, please review the following:

- There are potential benefits and risks of videoconferencing (e.g., limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the other person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance, preferably email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the hospital emergency department closest to your location, in the event of a crisis.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

New York Secure Ammunition and Firearms Enforcement Act (SAFE Act)

This section applies to clients in New York State.

I am required to make a report to the Director of Community Services (DCS) in the City of New York and/or the county where you reside if I believe you are likely to engage in conduct that would result in serious harm to yourself or others. In the City of New York, I would make this report to the Executive Deputy Commissioner of the NYC Department of Health and Mental Hygiene, who may then decide to report your name to the New York State Department of Criminal Justice Services (DCJS). The DCJS may then suspend or revoke your firearms license, or if you do not currently have a firearms license, may deem you ineligible for the issuance of a firearms license in the future.

Authorization for Consent to Treat

By signing below, I hereby authorize Dr. Geoffrey Steinberg to carry out such diagnostic and treatment procedures as may be necessary for my mental health care. Your signature below indicates that you have read the information in this document and agree to its terms during our professional relationship.

Client Name (Printed)

Client Signature/Date

Geoffrey Steinberg, Psy.D./Date

Parent/Guardian Consent for Minors

I certify that I am the parent or guardian of _____

I hereby authorize Dr. Geoffrey Steinberg to carry out such diagnostic and treatment procedures as may be necessary for my child's mental health care.

Minor's Name (Printed)

Minor's Date of Birth

Parent/Guardian's Name (Printed)

Parent/Guardian Signature/Date

Geoffrey Steinberg, Psy.D./Date

Recurring Billing Authorization

I hereby authorize Dr. Geoffrey Steinberg to bill my credit/debit card (as listed below) or checking account (voided check attached) for professional fees. Per the Outpatient Services Contract, I agree to charges for professional services including appointments that I elect to pay by credit/debit card/eCheck and missed appointments that exceed the annual allowance of free absences.

☐ Out-of-Network

Individual psychotherapy _____

☐ Aetna (In-Network) For Aetna-insured clients, your policy determines the deductible and co-insurance (percentage) or co-payment (fixed amount) for which you are responsible. This amount will be billed to your card or bank account on the day of service.

Deductible payment _____ (Annual deductible amount: _____)

Co-Payment / Co-Insurance _____

All clients are required to keep an active credit/debit card on file. Your card on file also will be charged in the event of any missed sessions that exceed the allowed number of free absences (see Cancellation Policy). If you would prefer to pay by electronic check, please attach a voided check when returning this form.

Cancellation fee _____

Declined transaction fee _____

☐ Visa ☐ Mastercard ☐ Discover ☐ American Express Is this a health savings flexible spending account? ☐ Yes ☐ No		
Name as it appears on card		
Card number		
Expiration	Security code	Zip code
Address associated with this card, if different from your mailing address on file:		
Email address where you would like receipts sent:		

I hereby authorize Dr. Geoffrey Steinberg to bill the account I have provided for professional fees as described above.

Client signature & date _____

Notice of Privacy Practices

Introduction

The Federal Health Insurance Portability and Accountability Act (HIPAA) requires mental health professionals to issue this official Notice of Privacy Practices. This notice describes how information about you is protected, the circumstances under which it may be used or disclosed and how you may gain access to this information. Please review it carefully.

For psychotherapy to be beneficial, it is important that you feel free to speak about personal matters, secure in the knowledge that the information you share will remain confidential. You have the right to the confidentiality of your medical and psychological information, and this practice is required by law to maintain the privacy of that information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health and psychological information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff, and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g., a billing service), sites and locations of this practice may share medical information with one another for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

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. The following should help clarify these terms:

PHI refers to information in your health record that could identify you. For example, it may include your name, the fact you are receiving treatment here, and other basic information pertaining to your treatment.

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

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

Authorization is your written permission to disclose confidential health information. All authorizations to disclose must be made on a specific and required form.

Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. For example, with your written authorization I may provide your information to your physician to ensure the physician has the necessary information to diagnose or treat you.

Payment Your PHI may be used, as needed, in activities related to obtaining payment for your health care services. This may include the use of a billing service or providing you documentation of your care so that you may obtain reimbursement from your insurer.

Health Care Operations are activities that relate to the performance and operation of my practice. I may use or disclose, as needed, your protected health information in support of business activities. For example, when I review an administrative assistant's performance, I may need to review what that employee has documented in your record.

Written Authorizations to Release PHI

Any other uses and disclosures of your PHI beyond those listed above will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization at any time, in writing.

Uses and Disclosures without Authorization

The ethics code of the American Psychological Association, Pennsylvania State law, and the Federal Health Insurance Portability and Accountability Act (HIPAA) regulations all protect the privacy of communications between a client and a mental health professional. In most situations, I can only release information about your treatment to others if you sign a written authorization. Such authorizations will remain in effect for a length of time you and I determine. You may revoke an authorization at any time, unless I have taken action in reliance on it. However, there are some disclosures that do not require your authorization. I may use or disclose PHI without your consent in the following circumstances:

Child Abuse – If I have reasonable cause to believe a child may be abused or neglected, I must report this belief to the appropriate authorities.

Adult and Domestic Abuse – If I have reason to believe that an individual such as an elderly or disabled person protected by state law has been abused, neglected, or financially exploited, I must report this to the appropriate authorities.

Health Oversight Activities – I may disclose your PHI to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information by any party about your treatment and the records thereof, such information is privileged under state law, and is not to be released without a court order. Information about all other psychological services (e.g., psychological evaluation) is also privileged and cannot be released without your authorization 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 must be informed in advance if this is the case.

Serious Threat to Health or Safety – If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.

Worker's Compensation – I may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Special Authorizations

Certain categories of information have extra protections by law, and thus require special written authorizations for disclosures.

Psychotherapy Notes – I will obtain a special authorization before releasing your Psychotherapy Notes. Psychotherapy Notes are notes I may make about our work during individual, group, joint, or family counseling sessions, which I have kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

HIV Information – Special legal protections apply to HIV/AIDS related information. I will obtain a special written authorization from you before releasing information related to HIV/AIDS.

Alcohol and Drug Use Information – Special legal protections apply to information related to alcohol and drug use and treatment. I will obtain a special written authorization from you before releasing information related to alcohol and/or drug use/treatment.

You may revoke all such authorizations (of PHI, Psychotherapy Notes, HIV information, and/or Alcohol and Drug Use Information) at any time, provided each revocation is in writing, signed by you, and signed by a witness. 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 or where law provides the insurer the right to contest a claim under its policy.

Patient's Rights and Psychologist's Duties

Patient's Rights

Right to Request Restrictions – You have the right to request restrictions on certain uses/disclosures of PHI. However, I am not required to agree to the request.

Right to Receive Confidential Communications by Alternative Means – You have the right to request and receive confidential communications by alternative means and locations. (For example, you may not want a family member to know that you are in treatment. On your request, I will send correspondence to another address.)

Right to Inspect and Copy – You have the right to inspect or obtain a copy of PHI in my records as these records are maintained. In such cases I will discuss with you the process involved.

Right to Amend – You have the right to request an amendment of PHI for as long as it is maintained in the record. I may deny your request. If so, 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 all disclosures of PHI. I can 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 of Privacy Practices from me upon request.

Psychologist's 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 our next session, or by mail at the address you provided me.

Complaints

If you believe your privacy rights have been violated, you may file a complaint. You will not be penalized or discriminated against for filing a complaint.

In Pennsylvania, contact the Pennsylvania Department of State complaint line 1-800- 822-2113.

In New York, complaints must be submitted in writing to the Office of the Professions. Visit http://www.op.nysed.gov/opd/complain.htm or call 800-442-8106 for more information.

Effective Date, Restrictions, and Changes to Privacy Policy

New York effective date: November 1, 2006.

Pennsylvania effective date: May 1, 2017.

Most recent text update: October 3, 2022.

Acknowledgment of Receipt of Notice of Privacy Practices

Client Name:_____ Date of Birth:_____

By signing below, I acknowledge that I have received a copy of this practice's Notice of Privacy Practices and have therefore been advised of how this practice may use and disclosure my protected health information and how I may obtain access to and control this information.

I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to psychotherapy notes, HIV related information, and alcohol and substance abuse information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date:_____

Relationship to client (if signed by a personal representative of the client):

_____