Jan F. Sherbak, PsyD

Patient Information

Date: _____

Name: _____
First Middle or Maiden Last

Street Address: _____

City: _____ State: _____Zip: _____

Preferred Phone: _____Email Address: _____

Date of Birth: _____ Age: _____ Soc. Sec. No: _____

Sex: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐Divorced

If married, name of spouse: _____

In case of emergency please contact: _____

Relationship:_____Phone:_____

Employer Name: _____Phone: _____

Are you a student? ☐ Yes ☐ No If so? ☐ Part-time ☐ Full-time

Referral Source: _____

Responsible Party Payment Information

Financially responsible party: Self ☐ Other ☐
If self, give billing address below:

_____

Please provide the following information about the Financially Responsible Person, IF it is not the patient:

Name: _____ DOB: _____ Age: ____ SS#: _____

Relationship to patient: _____ Home phone: _____

Employer: _____ Work Phone: _____

Billing Address: _____

Patient Name:_____

Are you the legal custodial guardian? ☐ Yes ☐ No

If you are not the legal guardian, a signed consent form is required from the custodial guardian. If you are divorced, copies of the divorce papers stating your legal guardianship are required prior to treatment.

Insurance or Health Plan Information

Primary Insurance Company: _____

Policy Holder's Name: _____ Date of Birth: _____

Employer: _____Relationship to Patient: _____

Subscriber ID#:_____ Group#: _____

Claims Address: _____Phone#: _____

Secondary Insurance **will not** be filed by this office. Please contact your insurance company and they should be able to help your file secondary claims.

Request for Confidential Handling & Restrictions in Release of Protected Health Information

As a service to you, Therapy Appointment Scheduler will remind you of your appointments via 1) phone call/message to your home phone, 2) email or3) text message. When you provide intake information to my assistant, please discuss with her your preferred method for receiving reminders. Reminders are a courtesy only. It is your responsibility to keep up with your schedule appointments.

Please list below any restrictions you want on the release of your protected health information:

Patient Name:_____

Financial Agreement and Informed Consent for Care

I understand that should there be other parties that may have partial financial responsibility for treatment of me or my child that it is my responsibility to pay for services rendered in full. I acknowledge that the recovering of payments from the other responsible party is then my responsibility and not that of the provider.

I accept responsibility for payment of charges for services rendered to the above named patient. I understand that full payment and/or my co-payment and/or deductibles are expected at the time services are rendered unless the doctor agrees otherwise. I understand that, as a courtesy, the doctor will file insurance claims for the services provided; however, this does not release me of my responsibility for payment of the charges for services. Payment for any charges denied or not covered by my insurance company becomes my responsibility and I agree to pay these charges. I also understand that any court order I have is an agreement between me and the courts **not** the doctor and I am still responsible for payment of all charges. I understand and agree that I may be charged for and required to pay for missed appointments not cancelled at least 24 hours in advance. I further understand and agree that a collection agency and/or the courts may be used in the event of delinquent payment, and I realize that such action could require that the doctor release to the collection agency, attorneys, and/or the courts, information which identifies the parties involved, gives the patient diagnosis, and describes the dates and nature of the charges, as well as all other information contained on any claim filed. In addition if I have requested that the doctor file the charges to my insurance company, I understand that securing benefits under health insurance or other health plans will require that the doctor provide the plan management with confidential patient information, including diagnosis and the dates and type of service rendered. Further, I understand that for utilization review, quality assurance, and other claims review purposes, it may sometimes be necessary for the doctor to provide the plan management with additional information concerning case history, presenting problems, treatment plans, prognosis, and other case information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health care claims made by or on behalf of the above named patient. This consent shall remain in effect until all claims have been fully processed and all review procedures completed.

By signing below, you acknowledge having read, understood, and agreed to the policies and procedures outlined in the **Patient Agreement with Policies and Procedures and Informed Consent for Care** handout provided to you. Your signature acknowledges your informed consent for care.

_____ _____

Signature for adult patient or parent/ legal guardian of patient less than 18 years of age

Date

Patient Name:_____

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law", HIPAA provides patient protections related to the electronic transmissions of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients with a notification of their privacy rights as it is related to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. The Practice Policies & Consent for Counseling Services document included in this initial paperwork is intended to inform you of your rights in a simple, yet comprehensive fashion. Please read this document thoroughly as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and you will find we will do all that we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask your provider for further clarifications.

By law, we are required to secure your signature indicating you have been provided and know you may request a copy of the Patient Agreement with Policies and Procedures and the Financial Agreement and Informed Consent for Care document. Thank you for your thoughtful consideration of these matters.

Jan F. Sherbak, PsyD

I, _____, understand and have been provided a copy of the **Patient Agreement with Policies and Procedures and Informed Consent for Car**e document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgement form.

_____ _____

Patient Signature or Parent of Minor or Legal Charge Date

If Legal Charge, describe representative authority: _____