WELCOME TO OUR OFFICE

Jenna Tedesco, Psy.D.

The Present Center for Mindfulness and Healing, LLC
2607 North Harrison Street
Wilmington, DE 19802

Patient Information

Name ________________________________ Home Phone _______________________

Address ______________________________ Work Phone _______________________

______________________________ Cell Phone _______________________

Preferred Contact: Home Work Cell E-mail (Circle One) E-mail ___________________________

May I call and leave a message for you at: **Home:** Yes or No **Work:** Yes or No **Cell:** Yes or No

Any special instructions about leaving messages: ____

SSN ______-______-________ Date of Birth _______________________

Relationship Status ____________________ Family Physician ____________________

Who referred you? ____________________ Phone Number ____________________

Insurance Information

Member Name ____________________ Insurance Company ____________________

Member ID ____________________ Phone (on Back of Card) ____________________

Group Number ____________________ Employer ____________________

Office Use : Effective Date ______________ Deductible ____________________

Copay ______________ Effective ____________________

Out of Pocket ______________ ____________________

Person Responsible for the Bill (if other than self):

Name ________________________ Home Phone ________________________

Address ________________________ Work Phone ________________________

________________________ Cell Phone ________________________

SSN ______-______-________ Date of Birth ________________________

Relationship to Patient: Spouse Parent Other ________________________________

☐ I understand that I am responsible for the payment of my bill in full. If I plan to submit my expenses to insurance, I can request a receipt with the required information.

☐ I also understand that a minimum of 24 hour notice must be given to cancel an appointment or I will be responsible for payment in full at the next appointment.

Signature ____________________________________ Date ________________ Rev. 2/17

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HIPPA Notice Form

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

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

1. **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 and some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
  - 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 obtain reimbursement for your healthcare. Examples of payment are when I 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 operations 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 my office, practice, group, etc. such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office, practice, group, etc. such as releasing, transferring or providing access to information about you to other parties.

2. **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 great 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.

3. **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 causes, on the basis of my professional judgment, to suspect abuse of children with whom I come into contact in my professional capacity. I am required by law to report this to the Department of Public Welfare.
- **Adult and Domestic Abuse:** If I have a reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), I may report such to the local agency which provides protective services.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services I provides you or the records thereof, such information is privileged under state law, and I will not release the information without your written consent, 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 you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and I determine that you are likely to carry out that threat, I must take a reasonable measure to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.

4. Patient's Rights and Psychologist's Duties and Patient Rights:

- **Right to Request Restrictions:** You have the right to request restriction 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 3 of this Notice). On your request, I will discuss with you the details of the accounting process.
- **Right to 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.

5. 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. If I revise my policies and procedure, I will notify you by mail. I reserve the right to change the privacy policies described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

6. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to you records, you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

7. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on January 1, 2016. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail.

Signature: ______________________________ **Date:** ______________________

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I understand that I am ultimately responsible for all charges. In the event a third-party payer (such as my health insurance plan) does not pay my therapist for any billed sessions or other fees, I accept responsibility for paying those fees.

I understand that appointments reflect professional time set aside by my therapist for me and will do my best to make all scheduled appointments or to cancel them with at least 24 hours notice.

I accept responsibility for paying a $75.00 fee for each appointment broken without at least 24 hours notice.

Schedule Of Fees

Amount	*Service Provided*
$150.00 per Hour	Session Time
$350.00 per Hour	Any and all documentation preparation and compilation for court.
$4000.00 per Day	One day in court. Must be paid in full by day of appearance.
$150.00 per Hour with 15 Minute Minimum	Any contact with providers, agencies, schools, etc.
$300.00 per Hour	Court consultation via telephone. One hour minimum billed.
$350.00 per Hour	All services related to psychological testing *not* covered by insurance. Including scoring and report compilation.

_______________________________________ ________________

_______________________________________ ________________

Patient, parent, or legal guardian signature Date

_______________________________________ ________________

Witness Date