Behavioral Health Practice

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HIPAA NOTICE OF PRIVACY PRACTICES AND CONSENTS

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

DATE:

TREATMENT: Use and disclose information to provide, manage or coordinate care with consultants and referral sources. This document is for use to verify insurance and coverage; along with processing claims and collecting fees.

****SAFETY PLAN: If you are ever in crisis (harm to self and others), you are directed to get help by contacting Lifeline at 275-5151, calling 211, 911, or proceeding to the nearest Psychiatric Emergency Room (Rochester Regional or Strong Memorial Hospitals) are the local centers.

**Currently your payment is expected for services at the beginning of our sessions. Fees are $90.00 for an initial session, 80.00 Individual, 80.00 Video/Phone Teleconference per therapy hour. Phone Consultation/ Collateral Contact sessions are private pay at the same commensurate rate. Should court time or paper work be required you will be responsible for therapy fees incurred.

** 24 hours notice is required for changing or cancelling session time. If you miss your scheduled appointment without 24 hours notice, you will be charged the private payment for that time (insurance will not be used). Thank you for your understanding.

Use and disclosure of protected health information for the purposes of providing services. Providing treatment services, collecting payment, and conducting healthcare operations are necessary activities for quality care. State and federal laws allow me to use and disclose your health information for these purposes. Information is released only in accordance with the state and federal laws and the ethics of the counseling profession. In the unlikely event of my incapacitation, my designee of records is Lena Kieliszak LMHC 585-330-2219.

HEALTHCARE OPERATIONS Use and disclose health information for *Review of treatment procedures

*Certifications *Review of business activities *Staff training *Compliance and licensing activities. OTHER USES AND DISCLOSURES *Mandated reporting *Appointment scheduling *Treatment alternatives *Emergencies*Criminal damage.

Name:_____ Birth Date_____

Home Address_____City/State/Zip_____

Phone: cel _____Work_____

Email Address: _____

May I send a text regarding your scheduled session?

I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when they are located at a different site than the provider; and hereby consent to have Laurie Agnello provide health care services to me telehealth/telemedicine.

Permission to release records:

I understand and give permission that my records may be released to my Primary Care Physician and/or Referral Sources as needed to ensure best practices for my comprehensive health care.

Primary Care Physician_____

Address_____

Phone_____ Fax#_____

Emergency Contact Person/Relationship &
Phone_____

I have been fully informed of the confidentiality and professional consents and I agree to all conditions and terms. I the event that you no longer require counseling please have a conversation with me: should more than 3 months pass your case will close. If you ever are concerned about the course of treatment please feel free to discuss with me without fears, as improvement with your mental health is my greatest priority.

Signature_____ Date_____

Signature of Parent/Guardian if under 18 yrs.
old_____