Personal Information Form

Patient Name: _____DOB: _____

Referred by/ Where Did You Hear about Dr. Elise: _____

Would you like to receive our newsletter? Y N

Address: _____

_____

Phone: (home) _____ Primary Care Physician: _____

(cell) _____ _____

(work) _____ _____

E-mail: _____

List Medications, Dosage, & Prescribing Doctor's Name

_____

_____

For patients younger than 18 years of age, please complete the following:

Parent/Guardian: _____

Address: _____

_____

Phone: (home) _____

(cell) _____

(work) _____

Parent/Guardian: _____

Address: _____

_____

_____

Phone: (home) _____

(cell) _____

(work) _____

Financial Agreement

I understand that payment is expected at the time of service. A fee of $25 will be assessed for any returned checks. I understand that I will be responsible for full payment if I do not give 24 hours notice of cancellation or change of appointment. I understand that my insurance company will not be responsible for this payment. I also understand that failure to maintain responsibility for payment may result in my account being sent to an independent agency for collection. I consent to the release of information for this purpose, and I agree to pay any costs associated with such collection. I authorize Elise G. Abromson, Psy.D.,LLC to release any medical or mental health information necessary to help me process insurance claims.

_____ _____

Patient/Parent/Guardian Date

OUTPATIENT SERVICES CONTRACT

Welcome to Elise G. Abromson, Psy.D., LLC, located in Healing Circles Wellness Center. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. I primarily use Cognitive Behavioral techniques to deal with the issues that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

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 first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation during the first two sessions. If psychotherapy is begun, I will usually schedule one 45-50-minute session per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide **24 hours advance notice of cancellation** (The only exception to this is inclement weather). If you do not notify me of your cancellation 24 hours in advance, you will be charged for that appointment. If it is possible, I will try to find another time to reschedule the appointment. If there is a time that same week, you will not be assessed a late charge. Lateness on the part of the client does not alter the session fee or the ending time of the session. Lateness on the part of the therapist will always be made up.

PROFESSIONAL FEES

My hourly fee is **$200** for the initial intake session and **$180** for subsequent sessions**.** In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, school observations, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge **$300** per hour for preparation and attendance at any legal proceeding. Furthermore, there is a **charge of 4 hours** to hold half the day for appearing in court whether I am called to appear or the case is dismissed. Dismissal of a case requires 48 hours notice to not be charged. Additional time with be added to that fee if I am required to be there longer than 4 hours.

BILLING AND PAYMENTS

Payment is expected at the time of service. No exceptions. If for some reason you are unable to pay at the time of service, you have **48 hours** to bring your payment.

Payment must be received by 5:00 p.m. within 48 hours (2 business days). If payment is not received at that time, a $25 late fee will be assessed to your account. You are responsible for paying this fee along with your original payment. Payments that are over 1 week late will be assessed a $50 late fee. Each week that the payment is not received, an additional $25 will be assessed to your account. If this fee, along with your original payment, is not received within 2 weeks, Elise G. Abromson, Psy.D., LLC may seek outside sources to collect the payment. The client is responsible for all fees associated with this process as well as all the late fees incurred. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

Payment can be mailed or dropped off in the locked mailbox on the side of the building (if you are facing the building in the parking lot, it is located on the right side of the building, by the side stairs, under the car port to the left). DO NOT leave the payment in the

front mailbox with the brochures or in the building if Dr. Abromson is not present. This is not secure and Elise G. Abromson, Psy.D., LLC is not responsible for payments placed anywhere but the locked mailbox.

INSURANCE REIMBURSEMENT

As a Licensed Psychologist, my professional services qualify for patient reimbursement under most insurance plans and are considered to be within the usual and customary range set by most insurance companies. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.
You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). 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, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Fees for Service:

- Initial Evaluation/ Intake Session (60 minutes) $200
- 45-50 minute individual/family therapy session $180
- Family Therapy w/ 3 or more members $180
- Phone consultations are charged based on the hourly rate
- Report and letter writing $180 (per hour)

Services not listed on here will be provided in a separate contract with their prices.

Payment is due at time of services and a statement will be provided which can be submitted for insurance reimbursement.

CONTACTING ME

I am often not immediately available by telephone and, although I may be in my office, I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

With your signature below you authorize me, or my representative in an emergency, to leave messages on your voicemail at home and/or on your cell phone. Please be advised that information transmitted on a cell phone may be at risk for interception by a third party.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

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

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

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____

Signature of Client/ Parent/ Guardian

_____

Elise G. Abromson, Psy.D.

Credit Card Form

I _____ authorize Elise G. Abromson, Psy.D., LLC, ("Dr. Elise Abromson") to keep my credit card (the "Credit Card") on file.

I understand that my credit card will be charged if I have a **late cancellation (less than 24 hours)**, **missed appointment**, **if I have a child or the child for whom I am custodian comes without me and without payment**, **if I do not have a form of payment for my session, or any combination thereof**. The Credit Card will be charged in these situations and you will be notified by invoice of the amount and nature of the charge.

Dr. Elise G. Abromson will not use your credit card information for anything other than payment for the services listed above. Dr. Elise G. Abromson will not release the Credit Card information to anyone aside from the service providers allowing for the transaction to be completed. Your information will be kept in a secure location.

Type of Credit Card: Visa Mastercard Debit/ Check Card

Credit Card Number_____

Expiration Date _____

Security Code (Last 3 Digits on back of card) _____

Pin Number (for check and debit cards only) _____

Address (numbers only, not street name) _____

Zip Code _____

Signature_____

Printed Name_____

Clinicians Signature_____

HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. Please review it carefully.

In compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Elise G. Abromson, Psy.D., safeguards the protected health information of people who receive services from her.

Protected health information includes descriptive information that can be used to identify a person and that relates to the physical or mental health or condition, the health care provided to the person, or payment for the health care. The protected health information includes information from the past, present, or future. The right to privacy continues after death.

You have the right to expect that only those individuals, organizations and/or agencies that have a need to know will be granted permission to use your protected health information, unless otherwise allowed by law or by your written authorization.

This notice will explain your rights more completely. These rights are the same as rights under 34B MRSA § 5605 et seq., Rights of Recipients of Mental Health Services, or Rights of Recipients of Mental Health Services who are Children in Need of Treatment.

1. Who I am

This notice describes the privacy practices of the Elise G. Abromson, Psy.D.,, including all psychotherapy services.

2. My Privacy Obligations

I am required by law to keep your protected health information private, to tell you about these rules and to follow the rules.

3. Disclosing and Using Your Information with your consent

When you begin receiving services from me, I will ask that you (or your legally authorized representative) to sign a consent form, which will permit me to release information about you in order to provide services to you, in order to be paid by your insurance company for the services provided to you, and to conduct our regular business activities.

Your consent will permit me to share information with other parties who provide services to you when you give consent to do so. I will specifically ask your permission to share information related to psychotherapeutic treatment.

I will share information with

- Providers in the community who provide services to you,
- Your insurance company, so your services will be paid for

I will also share information to resolve any complaints or grievances that you may have.

You may request to have the use or disclosure of your protected health information restricted. I do not have to agree to the restriction you request. If I do agree, I must make a record of the restrictions and I must honor them.

If you wish to have information provided to other parties, you will be asked to sign an authorization. The authorization will allow me to provide information to others. I cannot provide information that was given to me by someone else. You may revoke this authorization at any time by providing a written dated notice.

4. Using Your Protected Health Information for Other Purposes

Generally, I may use your protected health information for other reasons only when I have a specific authorization signed by your or your legally authorized representative. I will use your protected health information when necessary to contact you about appointments and to provide you with information I think you may be interested in. You may provide me with another address or method to contact you and I will honor that request.

There are some times when I may be unable to obtain your consent or an authorization and I will still need to use your protected health information. I will use only what is absolutely necessary to accomplish the purpose. Examples of when I might use protected health information about you without consent or authorization include:

- If you need emergency treatment
- If you are incapacitated and I believe you would consent if you could
- If I find any of these situations, which I am legally required to report:
  - Cases of suspected abuse and neglect of children and incapacitated adults
  - If I believe you represent a threat to the safety of someone in the community or your

Acknowledgment of receipt of notice of privacy practices

By my signature below, I _____, acknowledge that I received a copy of the Notice of Practices for Elise G. Abromson, Psy.D., Licensed Psychologist at Elise G. Abromson, Psy.D., LLC, located in Healing Circles Wellness Center.

_____ _____

Client signature (or personal representative) Date

If a personal representative signs on behalf of the client, please complete the following:

Personal Representative's name: _____

Relationship to the client: _____

_____

For office use only

_____

I attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

Individual refused to sign
Communications barriers prohibited obtaining the Acknowledgment
An emergency situation prevented us from obtaining Acknowledgment
Other

_____

_____