CONSENT FOR TREATMENT AND HEALTH CARE OPERATIONS

I,_____, hereby authorize, **Erin Cornelius, Ph.D.,**
(Name of client/guardian)

And his/her business associates to provide treatment and carry out healthcare operation including billing. The specific operations are:

a. Billing 3rd party insurances
b. Sending self pay bills to your home
c. Utilizing administrative staff to carry out operations that are necessary to maintain schedules and charts
d. Verifying insurance eligibility
e. Contacting insurance companies for authorization to begin and to extend number of sessions
f. Contacting insurance companies and primary care physicians to obtain referrals

g. Allow your insurance company to review your file, including chart notes

h. Other:_____
(specify)

This consent form will be in effect for a period of no more than 3 years or when all communications with third parties for payment is completed, whichever occurs first.

I understand that my records are protected under the Health Insurance Portability and Accountability Act (HIPAA) and cannot be disclosed without my written consent. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as described above or on following date._____.

Signature of Client:_____ Date: _____

Signature of Guardian:_____ Date: _____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I,_____, hereby authorize, **Erin Cornelius, Ph.D.,**
(Name of client/guardian)

to release to and to receive from:

_____

_____

the following information about:_____

INFORMATION TO BE RELEASED

_____1. Copies of chart notes.

_____ 2. Copies of entire record, i.e., chart notes, billing information, reports prepared by therapist, etc. (not necessarily including therapist's personal notes).

_____ 3. Summary of impressions, diagnosis, treatment, response to treatment, history, recommendations, psychological test results. (may include copies of reports prepared by therapist).

_____4. Copies of computer-generated test reports.

_____ 5. Other (specify) _____

PURPOSE OF DISCLOSURE

This authorization allows your mental health provider to send/receive the above information to/from the above-named parties. (In addition, a thank you letter to the referring agency or individual is sometimes sent.) The specific purpose(s) of this disclosure (is/are):

_____ 1. To coordinate with other health/mental health providers

_____ 2. To obtain insurance or employment or government benefits.

_____ 3. To coordinate with attorneys, judges, probation officers, etc.

_____ 5. To coordinate with school officials/teachers, etc.

_____ 6. To obtain/provide history.

_____ 7. Other _____

I understand that my records are protected under the Health Insurance Portability and Accountability Act (HIPAA) and cannot be disclosed without my written consent. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as described below.

EXPIRATION DATE:_____

Signature of Client or Parent/Guardian _____ Date:_____
(indicate relationship to client)

Signature of Witness: _____ Date: _____

PLEASE COMPLETE

It is our hope to provide the highest quality of service. Below you will find a patient information sheet which provides our office with useful information that is helpful to our staff in contacting you, processing your billing and notifying you in case of an office closing, etc.

PATIENT INFORMATION SHEET

Patient Name_____Maiden Name_____Marital Status:_____

Date of Birth_____SS# _____

Parent/Guardian _____

Complete Address _____

City _____ State _____ Zip Code_____Length of time there _____

Home phone #_____Cell Phone# _____

Employer_____Work Phone#_____Extension_____

Closest Relative (Not Spouse) _____ Relationship_____

Telephone _____

Name of Church/Affiliation_____Referral Source _____

Spouse/Legal Guardian Name_____

Address (if different from above) _____

Date of Birth_____SS#_____Telephone _____

Employer_____Job Title _____

Work Telephone_____Extension_____ Length of time there _____

MEDICAL INFORMATION

Primary Care Physician Name _____

Physician's Address _____

Insurance Carrier_____ID#_____Group _____

Policy Holder Name_____Policy Holder's Date of Birth: _____

Address (if different from above) _____

*A 24-hour cancellation notification is required. There will be a late cancellation fee charged for appointments cancelled without at least a 24 business hour notice. This fee is NOT billable to any insurance carrier.

**PLEASE NOTE: You will be held liable for any collection costs and/or attorney fees in the event those services are needed to collect this debt.

***By signing this form, you are indicating that you have read and understand the accompanying office policies.

Signature_____Date _____

Erin Cornelius, PH.D.

Western New York Psychotherapy Services

70 Linwood Ave.
Orchard Park, New York 14127
Telephone: (716) 675-9232
Fax: (716) 675-9217

MISSED APPOINTMENT AND LATE CANCELLATION POLICY

My practice requires that in the event you have to cancel and appointment, you must notify us one business day (24 hours) in advance. There is a fee for appointments canceled with less than 24 hours notice and a fee for appointments, which are missed with no contact in advance at all. None of these fees are insurance reimbursable.

I would like to emphasize that there are no exceptions to the above policy. In other words, the policy applies even if there is a good reason, such as a personal emergency that requires you to cancel your appointment. If there is a snow emergency and the police announce a driving ban and you call in advance of your appointment to cancel, we generally waive the cancellation fee.

On the other hand, my office has procedures, which may, in some instances, permit you to avoid such charges. Specifically, if you do cancel with less than 24 hours notice, my office will try to find someone to take your canceled appointment. If the office is successful, you will not be charged the late cancellation fee.

I also understand that I am responsible for this fee and it is not billable to my insurance. I have discussed these fees with my therapist and fully understand them.

SIGNATURE:_____

DATE: _____

Western New York Psychotherapy Services

315 Alberta Drive, Suite 211
Amherst, New York 14226
Phone: (716) 837-6705
Fax: (716) 837-6759

70 Linwood Ave.
Orchard Park, New York 14127
Phone: (716) 675-9232
Fax: (716) 675-9217

Western New York Psychotherapy Services has implemented an automatic courtesy call system. If you are interested in receiving an automated courtesy call, please fill out the information below and return this form to the front desk receptionist. **Please note that only one phone number can be listed for these calls.** It is only possible for us to provide a courtesy call to one parent. The information being disclosed will be the clinician's name and the date and time of the appointment.

Patient Name: _____

Would you like to receive a courtesy call prior to your appointment? Yes_____No _____

Please indicate the phone number you would like for us to use: _____

In the near future, we also will be providing the option of receiving emails or texts instead of a phone call. Please indicate below if you want the following options:

_____ TEXT – Number to be used: _____

_____ EMAIL – Address to be used: _____

There may be times when you are unable to make/change appointments yourself and/or require another party to check billing status, etc. Please indicate below if there is another party we can talk to regarding appointments, billing issues, etc.

Name:_____
Relationship to Patient: (Spouse, Parent, Etc.) _____
Not Applicable: _____

Please be aware that, by signing this form, you are releasing WNY Psychotherapy Services from any liability associated with leaving or receiving information regarding your appointment and billing status.

Signature:_____Date: _____

Acct #_____(office use only)

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Billing Policy

Please be aware that co-payments, co-insurances, etcetera are due at the time of service. A $5 (five dollar) billing fee will be added to your account if the time of service requirement is not met. If your insurance policy includes a deductible, you must pay the entire allowable fee at the time of service as well. The above billing fee applies if this requirement is not met. If your insurance company notifies us that your deductible has been met, your account will be credited the appropriate amount. If we are certain that your deductible has been met at the time of service, the appropriate co-payment or co-insurance applies.

All co-payments for services provided to a child are the responsibility of the person bringing the child to the visit, even if you have a separation or divorce agreement that states otherwise. It is up to you to work out financial responsibility with the other parent.

Please note that an additional fee will be added each month that the balance remains outstanding. For example, after two months the billing fee will be $10.00 (ten dollars). Also, if co-pays and/or deductibles are not made at the time of service, additional visits may not be scheduled and/or future appointments may be office cancelled.

Please be aware that if, at any time, there is a *change of insurance*, our billing office must be notified of the new insurance information *at least* **3 days prior** to your next scheduled appointment. If new insurance information is received at the time of your appointment, the appointment will be considered **self-pay** until the insurance is verified by our billing office. Not all therapists participate with every insurance plan and some plans require pre-authorization in order for the insurance company to reimburse for services provided.

If you have any further questions, please feel free to contact our billing office at (716)837-6705, option 4, Monday through Friday from 9am to 4pm.

_____ _____

(Patient/Parent Signature) (Date)

_____

(Print name)