

WNY Psychotherapy Services  
**NEW PATIENT INFORMATION FORM**

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Gender: ☐ Male ☐ Female

Employer/School \_\_\_\_\_

Address \_\_\_\_\_

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Medical Information**

Primary Care Physician \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Referring Physician \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information**

Primary Insurance Company \_\_\_\_\_ Effective Date: \_\_\_\_\_

Identification #: \_\_\_\_\_ Group#: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Effective Date: \_\_\_\_\_

Identification #: \_\_\_\_\_ Group#: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

## CONSENT FOR TREATMENT AND HEALTH CARE OPERATIONS

I, \_\_\_\_\_, hereby authorize, **Vicki Murphy, MS, PMHNP-BC,**  
(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 3<sup>rd</sup> 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, **Vicki Murphy, MS, PMHNP-BC,**  
(Name of client/guardian)

to release to and to receive from (COUNSELOR):

\_\_\_\_\_  
\_\_\_\_\_

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 \_\_\_\_\_  
(indicate relationship to client)

Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Date: \_\_\_\_\_

# AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, \_\_\_\_\_, hereby authorize, **Vicki Murphy, MS, PMHNP-BC,**  
(Name of client/guardian)

to release to and to receive from **(PEDIATRICIAN):**

\_\_\_\_\_  
\_\_\_\_\_

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) \_\_\_\_\_

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- \_\_\_\_\_ 5. To coordinate with school officials/teachers, etc.
- \_\_\_\_\_ 6. To obtain/provide history.
- \_\_\_\_\_ 7. Other \_\_\_\_\_

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**EXPIRATION DATE:** \_\_\_\_\_

Signature of Client or Parent/Guardian \_\_\_\_\_  
(indicate relationship to client)

Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Date: \_\_\_\_\_

# AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, \_\_\_\_\_, hereby authorize, **Vicki Murphy, MS, PMHNP-BC,**  
(Name of client/guardian)

to release to and to receive from **(SCHOOL):**

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) \_\_\_\_\_

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- \_\_\_\_\_ 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 \_\_\_\_\_  
(indicate relationship to client)

Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Date: \_\_\_\_\_

# Vicki Murphy, MS, PMHNP-BC

*Western New York Psychotherapy Services*

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

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

## **Missed Appointment Fee and Late Cancellation Fee Policy**

I, \_\_\_\_\_, have read the policies given to me, which not only explain the services available to me, but also explain my responsibilities and obligations, which include payment for services rendered and appropriate notice for sessions to be cancelled. I understand that a **24 business hour** notice is required to avoid a Missed Appointment or Late Cancellation Fee. (**Weekends and holidays are NOT considered business days.**)

In the event that I do not give such notice, only the following conditions with waive the fee:

- 1. If the roads are closed due to a weather emergency.*
- 2. If I am hospitalized.*

We would like to emphasize that there are generally no exceptions to the above policy. In other words, the policy applies even if there is a good reason, such as an emergency that requires you to cancel your appointment.

It is the practice of this office to offer courtesy calls. These are done on a daily basis. However, there are times when, due to circumstances beyond your control, we do not have that opportunity. You are responsible for keeping your appointments. **Please note that any messages left with the answering service are viewed as less than 24 business hour notice. Also, when cancelling a Monday appointment, you must phone by the appropriate time on Friday.**

I also understand that I am responsible for this **\$50.00** 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

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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)

# Western New York Psychotherapy Services

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

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

## 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.

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(Patient/Parent Signature)

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(Date)

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(Print name)



## Prescriptions

Starting March 26<sup>th</sup>, all prescriptions will need to be sent electronically to your pharmacy. This is being mandated by New York State. I will need to purchase new software and set up a file to facilitate your prescriptions being sent directly to your pharmacy. It is a secure date system.

Requests for refills will still need to give me one-week notice for request of refills on controlled substances (eg. Xanax, Clonazepam, Adderall, Ritalin)

Please fill out the information below. Please print clearly.

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Full Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_

I agree to have this information used to send scripts to my pharmacy.

\_\_\_\_\_

**\*\*Any change in your information (address, phone, pharmacy) will need to be submitted immediately.**