ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF POLICIES AND PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective Notice of Mental Health Practitioner's Policies and Privacy Practices. A copy of this signed and dated acknowledgment shall be as effective as the original.

Printed Name:_____ Signature: _____

Date: _____

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority.

Name: _____ Authority: _____

Thank you.

If you have any questions about this form, or the attached notice, please contact Dr. Jeff Perlman.

AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____(Insert Name of Patient/ Client), whose Date of Birth is _____, authorize Jeffrey Perlman, Ph.D., LCSW to disclose to and/ or obtain from: _____ (Insert Name of Person or Title of Person or Organization) the following information:

Description of Information to be Disclosed:

Patient / Client should initial each item to be disclosed.

__ Assessment
__ Diagnosis
__ Psychosocial Evaluation
__ Psychological Evaluation
__ Psychiatric Evaluation
__ Treatment Plan or Summary
__ Current Treatment Update
__ Medical Management Information
__ Presence/Participation in Treatment
__ Nursing/Medical Information
__ Educational Information
__ Discharge/Transfer Summary
__ Continuing Care Plan
__ Progress in Treatment
__ Demographic Information
__ Other: _____
_____
_____

Purpose: The Purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to (Jeffery Perlman, Ph.D., LCSW) at (561) 498-1160. I further understand that a revocation of the authorization is not effective to the extent that action has been reliance on the authorization.

Expiration: Unless sooner revoked, this authorization expires on the following date or as otherwise indicated:

Conditions: I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have any affect on any actions they took before that received the revocation.

Signature or Patient/Client: _____ Date: _____

Signature of Parent, Guardian or Personal Respective: _____ Date: _____

I understand that any disclosure is bounded by Title 42 of the Code of Federal Regulations (chemical abuse/addiction clients}, and Florida Statutes 294.459 (9b} and/or 90.503 (psychiatric/psychological information), and that redisclosure of this information without my additional written authorization is prohibited. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. This consent will automatically expire six (6) months after the date of this consent or on following earlier date of this consent, event of condition.

FEE AGREEMENT

In some instances, your insurance carrier may not pay their share for service. Should this be the case, you will be responsible for the following fee of _____ .

The fee is payable to **Jeffrey Perlman, Ph.D., LCSW** for psychotherapeutic services rendered. I understand that the fee is to be paid at each session, weekly, monthly, whichever is agreed upon by us.

As a courtesy, I, Dr. Perlman agree to furnish upon request appropriate documentation so that I may submit any claims directly to my insurance company for reimbursement.

I have read, understand and agree to the above.

Print Name: _____

Signature: _____ Date: _____

(HIPPA) FLORIDA NOTICE FORM

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

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PH I), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are 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 operation 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, clinic practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

• " Disclosure" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. 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 greater 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 (I) 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.

III. 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 know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child' s welfare, the law requires that I report such knowledge or suspicion to the Florida Department of Child and Family Services.

• Adult and Domestic Abuse: If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Centra l Abuse Hotline.

• Health Oversight: If a complaint is filed against me with the Florida Department of Health on behalf of the Board of Psychology, the Department has the authority to subpoena confidential mental health information from me relevant to that complaint.

• Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena 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: When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

• Worker's Compensation: If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

IV. Patient's Rights and Psychotherapist's Duties

Patient' s Rights:

• Right to Request Restrictions - You have the right to request restrictions 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. On your request, I will discuss with you the details of the request 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 regarding you. On your request, I will discuss with you the details of the accounting process.

• Right to a 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.

Psychotherapist 's 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.

• I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

• If I revise my policies and procedures, J will mail a letter to you indicating a change has been made and provide you a copy of the update notice.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Elizabeth Mahaney at 813-240-3237 or Jean Mulloy at 875-0728

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to Elizabeth Mahaney 3522 W. Azeele St. Tampa, Fl 33609

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14,2003.

I reserve the right to make changes in this notice, any changes to this notice will be mailed to you as well as posted in my office.

INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: (Last)_____ (First)_____ (Middle Initial) _____

Name of parent/guardian: (Last)_____ (First)_____ (Middle Initial) _____
(if under 18 years)

Birth Date:_____/_____/_____ Age: _____Gender: □ Male □ Female

Marital Status: □ Never Married □ Separated □ Domestic Partnership □ Divorced □ Married □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number) (City) (State) (Zip)

Home Phone:_____ May we leave a message? □ Yes □ No

Cell/Other Phone: _____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ Yes □ No

Please list:_____

_____

Have you ever been prescribed psychiatric medication? □ Yes □ No

Please list and provide dates: _____

_____

Jeffrey Perlman, Ph.D., LCSW

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please check)
   □ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

   Please list any specific health problems you are currently experiencing: _____

   _____

2. How would you rate your current sleeping habits? (please circle)
   □ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

   Please list any specific sleep problems you are currently experiencing: _____

   _____

3. How many times per week do you generally exercise? _____

   What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns: _____

   _____

5. Are you currently experiencing overwhelming sadness, grief, or depression? □ Yes □ No
   If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? □ Yes □ No
   If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ Yes □ No
   If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ Yes □ No

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ Yes □ No If yes, for how long? _____
    On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently: _____

    _____

    _____

Jeffrey Perlman, Ph.D., LCSW

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

		List Family member
Alcohol/Substance Abuse	□ Yes □ No	_____
Anxiety	□ Yes □ No	_____
Depression	□ Yes □ No	_____
Domestic Violence	□ Yes □ No	_____
Eating Disorders	□ Yes □ No	_____
Obesity	□ Yes □ No	_____
Obsessive Compulsive Behavior	□ Yes □ No	_____
Schizophrenia	□ Yes □ No	_____
Suicide Attempts	□ Yes □ No	_____

ADDITIONAL INFORMATION

1. Are you currently employed? □ Yes □ No If yes, what is your current employment situation? _____

_____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

2. Do you consider yourself to be spiritual or religious? □ Yes □ No If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths? _____

_____

4. What do you consider to be some of your weaknesses? _____

_____

5. What would you like to accomplish out of your time in therapy? _____

_____

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between your behavioral health provider(s) and your primary care physician (PCP) is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows your behavioral health provider to share valuable information with your PCP. No information will be released without your signed authorization. Once completed and signed, please give this form to your behavioral health provider.

Section 1. The Patient

Last Name: _____FirstName: _____ Middle Initial: _____

Subscriber Number From ID Card: _____Insurance Company Name: _____

Date of Birth (MM/00/YYYY): _____/_____/_____ Phone Number: _____

I hereby authorize the disclosure of protected health information about the individual named above.

I am: the individual named above (complete Section 8 below to sign this form)
a personal representative because the patient is a minor, incapacitated, or deceased (complete Section 9)

Section 2. Who Will Be Disclosing Information About the Individual?

The following behavioral health provider may disclose the information:

Name (a person, or an organization if you are naming a facility): _____

Phone Number (if known): _____

Section 3. Who Will Be Receiving Information About the Individual?

The information may be disclosed to the following primary care physician:

Name (a person, or an organization if you are naming a practice): _____

Phone Number (if known): _____

Address (if known): _____ City _____ State _____ Zip _____

Section 4. What Information About the Individual Will Be Disclosed?

Any applicable behavorial health and/or substance abuse information, including diagnosis, treatment plan, prognosis, and medication(s) if necessary.

Section 5. The Purpose of the Disclosure

To release behavioral health evaluation and/or treatment information to the PCP to ensure quality and coordination of care.

Section 6. The Expiration Date or Event

This authorization shall expire 1 year from the date of signature below unless revoked prior to that date.

Section 7. Important Rights and Other Required Statements You Should Know

- You can revoke this authorization at any time by writing to the behavioral health provider named above. If you revoke this authorization, it will not apply to information that has already been used or disclosed.

- The information disclosed based on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.

- You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services. This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.

- You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting your behavioral health provider named above.

Section 8. Signature of the Individual

Signature: _____ Date (required) _____

Section 9. Signature of Personal Representative (if applicable)

Signature: _____ Date (required) _____

Relationship to the individual (required): _____

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

SERVICE AGREEMENT FORM

Beginning psychotherapy is an important step you have taken toward improving the quality of your life. This is a collaborative process between us, and questions or comments may occur to you. It will be helpful if you let me know of them at any time. The following is information that may clarify some of your questions.

CONFIDENTIALITY

Everything discussed in sessions is privileged information and is kept in the strictest confidence, except in the following circumstances:

1. If you give written consent for the release of information about you (e.g., for me to consult with a physician, lawyer, or some other person with information about you that might be helpful in our work)

2. The law requires therapists to report suspected child or elder abuse or neglect, as well as any clear probability that you may seriously harm yourself or someone else

3. If a court orders the release of information

4. If the health insurance company or managed care plan that reimburses you requests information about your treatment in order to continue your reimbursements and you have waived confidentiality.

5. If you raise the issue of your mental status or competency in a legal proceeding

6. Therapists often participate in peer consultation with other equally trained clinicians. In such cases, however, no names or other identifying data are exchanged.

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

□ Home Telephone:
□ O.K to leave message with detailed information □ Leave message with call-back number only

□ Work Telephone:
□ O.K to leave message with detailed information □ Leave message with call-back number only

□ Written Communication
□ O.K. to leave mail to home address □ O.K. to mail to my work/office □ 0.K. to fax to this number

□ Other:_____

□ Emergency contact person/ telephone: _____

APPOINTMENTS AND FINANCIAL ARRANGEMENTS

The length of an individual psychotherapy session is 45 minutes. We will agree on the days and times for your sessions. As your session times are set aside just for you on a regular, there is a charge for missed appointments. If, however, you notify me at least 24 hours in advance, I will try to schedule a make-up session for you if possible. I do not charge for sessions cancelled because of your scheduled vacation or for unavoidable emergencies.

Payment of my fee is expected in a prompt manner, per session, weekly or monthly, whichever is agreed upon between us. I do not accept most insurance assignment, except in the case of Medicare and Florida Blue Cross Blue Shield. If you pay by check, do consider writing it out in advance so you do not lose time in your session to attend to it.

TELEPHONE CALLS

Should you feel you need some contact with me over the telephone, please feel free to call at any time. I do not interrupt sessions to answer the telephone, but I do check for messages frequently during the day or evening, and will respond to your call as soon as possible.

I have read, understand and agree to the above

Print Name: _____

Signature: _____Date: _____

Jeffrey Perlman, Ph.D., LCSW

ASSIGNMENT OF BENEFITS

Patient Name: _____ Phone: _____

Address: _____

Date of Birth (MM/DD/YYYY): _____/_____/_____ Social Security: _____

Referred By: _____

Primary Insurance Company: _____

Secondary Insurance Company: _____

A copy of your insurance card information will be made and kept on file.

I hereby authorize ***Jeffrey Perlman, Ph.D., LCSW***, to apply for Medicare Medigap, and other health insurance benefits on my behalf. I request payment of Blue Cross Blue Shield and other insurance carriers be made directly to the above provider. I certify that the information I have reported with regard to my insurance carrier is correct. I authorize the release of medical information about me to my health insurance carrier(s), and any and all other information to determine the benefits payable or related services.

_____ _____

Signature of Patient / Parent or Legal Guardian Date

_____ _____

Printed Name of Patient / Parent or Legal Guardian Date

FINANCIAL POLICY

If medical insurance information is received at the time of service, as a courtesy, a claim will be submitted to your insurance company. Insurance co-payments and annual deductibles not met or the year are payable to ***Jeffrey Perlman, Ph.D., LCSW****. When participating with an insurance carrier, services that are not fully reimbursed by your insurance company and are indicated by your insurance's Explanation of Benefits to be the patient's responsibility will be due and payable upon receipt of a billing statement. Unless you are covered by a government program (Medicare, Medicaid) or a private insurance that has an agreement that prohibits members from being billed and if correct insurance information or referral documentation is not presented at the time of service, you are responsible or the full charges incurred.*

I further understand that information communicated to the insurance carrier may be through electronic transmission, written, oral or by fax. A photocopy of this assignment is to be considered as a valid original. ***Information released is strictly for treatment, payment or healthcare operations allowed by law under HIPAA and Florida State Regulations****. This assignment of benefit will remain in effect until revoked by me in writing.*

_____ _____ _____

Signature Print Name Date

Patient Parent or Legal Guardian *Patient Parent or Legal Guardian*