

Counseling Office of Eileen Dewey, LCSW-C and Associatessm

Eileen Dewey, LCSW-C, SAP, Director
Mike Green, MHS, CSC-AD, BCPC
Drew Sandberg, MSW, LGSW

Judy Jakubowski, MS, CAC-AD
Stephanie Godiwala, MFT, LCMFT, SAP
Lauren Spivey, BA, ADT

Nicholas Scotto, MD

Today's Date: _____

Client Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

Emergency Contact Person: _____

Relationship: _____

Phone # _____

What is the primary purpose of today's visit? _____

Are you under the care of another provider at this time? _____

Name: _____ Phone # _____

Who referred you to us? _____

Were you referred to a specific provider? _____

Client Agreement

Welcome to our practice. This document includes important information regarding our professional services and regarding your rights and responsibilities as a patient.

Patient Rights

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law designed to limit the use and disclosure of your Protected Health Information (PHI). In accordance with HIPAA, your PHI will not be released to any entity without your express written consent.

Contacting your Clinician

Clinicians are often not immediately available by telephone, as they are at most times meeting with patients. The administrative staff member taking your call may be able to answer your questions and will leave a detailed message for your clinician. Every effort will be made to return your call within 12-24 hours.

Cancellation Policy

If you are unable to attend your scheduled session, it is important that you call. **We require at least 24 hours advanced notice for cancellations of individual appointments, or the full fee of the appointment will be charged.**

Fees

All fees are due at the time of service. If payment is not current, we are under no obligation to deliver services.

| | | | | |
|---|---------|--|---------------------------------------|--------|
| Initial Evaluation | \$175 | | Operation Breakthrough | \$350 |
| Psychiatric Evaluation | \$275 | | Urinalysis (standard) | \$40 |
| SAP Program | \$450 | | Urinalysis (special tests) | varies |
| Counseling (individual, family, marriage) | \$125 | | Insurance Forms or Pre-Authorizations | \$25 |
| Medication Management | \$125 | | Returned Check Fee | \$35 |
| Re-evaluation | \$75 | | Credit Card Transactions | +2% |
| Group Sessions | \$45-50 | | Fees as of 1/31/2013 | |

Consent

Be signing below I understand that I am voluntarily presenting for services. I acknowledge that I am responsible for all charges in connection with care and treatment rendered. I have read this form; I understand and agree to the contents of this form. I acknowledge receipt of the Privacy Practices.

Client Signature (or Parent if client is a minor)

Date

Consent for the Release of Confidential Information

(Your physician, spouse, counselor, etc.)

FULL CONSENT -- I authorize the Counseling Office of Eileen Dewey & Associates to release *any portion* of my client record to the person or organization I have written above; I further authorize the Counseling Office of Eileen Dewey & Associates to obtain information from the person or organization list above.

-OR-

LIMITED CONSENT -- I authorize the Counseling Office of Eileen Dewey & Associates to release *only* the following information to the person or organization I have written above:

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Print Patient's Name Date

This authorization will be valid for one year unless I otherwise specify

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

Patient Bill of Rights

As a client of the Counseling Office of Eileen Dewey & Associates, it is important to realize that you have both rights and responsibilities. You are entitled to:

Respect

- be treated with respect and courtesy
- receive safe, considerate, ethical and cost effective care
- have your individual cultural, spiritual and psychological needs respected
- have your privacy and personal dignity maintained
- be free from all forms of abuse, neglect and harassment
- expect that information regarding your care will be treated as confidential

Treatment

- receive treatment regardless of race, religion or any other discrimination prohibited by law
- expect reasonable continuity of care and to be informed of available and realistic care options when outpatient treatment is no longer appropriate

Information

- understand your treatment plan, as well as the possible outcomes, risks and benefits of your care, and be informed of any unanticipated outcomes.
- be advised of program policies, rules and regulations
- be aware of your program expectations
- know the names and titles of your counselors
- see your medical records and have the information explained or interpreted as necessary, except when restricted by law.
- review your bill and to have any questions or concerns adequately addressed
- be informed of the charges for services and available payment methods

Involvement

- be involved in decisions concerning your care
- choose to have your family members and/or others involved in decisions about your care
- choose to exclude your family members and/or others from participating in decisions about your care
- discuss any treatment planned for you
- give your informed consent or informed refusal for treatment

If you have questions or concerns, please call the Privacy Officer at 410-730-1333.