Sheila Harrington, LCSW

Patient Information Sheet

Date: _____

Name: _____
Address: _____
_____
Home #: _____ Work #: _____
Cell #: _____ Email: _____

Employer: _____
Occupation: _____
Address: _____
_____

Date of Birth: _____ Gender: _____
Ethnicity: _____ Religion: _____
Marital Status: _____ Current living situation: _____
Children (ages): _____

In case of Emergency: _____
Relation to Patient: _____
Home #: _____ Work #: _____
Cell #: _____

Primary Ins: _____ Cardholder: _____
Plan name: _____ Employer: _____
Insured ID #: _____ DOB: _____
Policy / group #: _____

I authorize payment of benefits directly to the therapist for the services provided:

AUTHORIZATION TO PAY BENEFITS TO PROVIDER:

_____ _____

Patient / Guardian signature Date

MontclairPsychotherapy.com
973-509-2370 | sheila@montclairpsychotherapy.com | 8 Hillside Ave, Suite 106 Montclair, NJ 07042

Sheila Harrington, LCSW

Cancellation Policy

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full fee of $200 is charged for missed appointments or no show cancellations with less than a 24 hour notice unless due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for or cancel an appointment.

Thank you for your consideration regarding this important matter.

_____

Patient Signature (Patient's Parent /Guardian if under 18) Date

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Limits of Confidentiality

Contents of all psychotherapy sessions are considered to be confidential. Both verbal information and written records about a patient cannot be shared with another party without the written consent of the patient or the patient's legal guardian. Noted exceptions are as follows:

When a patient discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the patient discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Duty to Warn and Protect:

If a patient states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Abuse of Children and Vulnerable Adults:

Mental Healthcare professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Prenatal Exposure to Controlled Substances:

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Minors/Guardianship:

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____

Patient Signature (Patient's Parent / Guardian if under 18) Today's date

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BEHAVIORAL TELEMEDICINE PATIENT CONSENT FORM

In order to receive telemedicine services from Sheila Harrington, LCSW, you must be located in the state of New Jersey at the time the behavioral telemedicine service is provided.

Behavioral telemedicine is the delivery of psychotherapy services using interactive audio and visual electronic systems between a provider and a patient that are not in the same physical location. These services may also include electronic prescribing, appointment scheduling, communication via email or electronic chat, electronic scheduling, and distribution of patient education materials.

The potential benefits of behavioral telemedicine are:

- Reduced wait time to receive behavioral healthcare.
- Avoiding the need to travel to behavioral healthcare.

The potential risks of behavioral telemedicine include, but are not limited to:

- A behavioral telemedicine session will not be exactly the same, and may not be as complete as a face-to- face service.
- There could be some technical problems (video quality, internet connection) that may affect the behavioral telemedicine session and affect the decision making capability of the provider.
- The provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you may require.
- A lack of access to all the information that might be available in a face-to-face visit, but not in a telepsychiatry session, may result in errors in judgment.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Sheila Harrington, LCSW utilizes software that meets the recommended standards to protect the privacy and security of the behavioral telemedicine sessions (HIPAA compliant). However, the service cannot guarantee total protection against hacking or tapping into the behavioral telemedicine session by outsiders. This risk is small, but it does exist.

Alternatives to the use of behavioral telemedicine:

- Traditional face-to-face sessions.

I understand that I have the following rights with respect to behavioral telemedicine:

- (1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- (2) The laws that protect the confidentiality of my medical information also apply to behavioral telemedicine. As such, I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
- I also understand that the dissemination of any personally identifiable images or information from the behavioral telemedicine interaction to researchers or other entities shall not occur without my written consent.
- (3) I understand that there are risks and consequences from behavioral telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my

medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

• In addition, I understand that behavioral telemedicine based services and care may not be as complete as face-to- face services. I also understand that if my psychotherapist believes I would be better served by another form of behavioral health services (e.g. face- to- face services) I will be referred to a behavioral healthcare provider who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of behavioral telemedicine, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improved, and in some cases may even get worse.
• (4) I understand that I may benefit from behavioral telemedicine, but that results cannot be guaranteed or assured.
• (5) I understand that I have a right to access my medical information and copies of medical records in accordance with New Jersey state law.

Patient's Responsibilities

• I will not record any behavioral telemedicine sessions without written consent from my provider. I understand that my provider will not record any of our behavioral telemedicine sessions without my written consent.
• I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.
• I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer that is used for behavioral telemedicine. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I understand that I must be a resident of New Jersey to be eligible for behavioral telemedicine services from Sheila Harrington, LCSW.
• I understand that my provider determines whether or not the condition being diagnosed and/or treated is appropriate for a behavioral telemedicine encounter.
• I understand that if the behavioral telemedicine session does not achieve everything that is needed, then I will be given a choice about what to do next. This could include a follow up face-to- face visit, or a second behavioral telemedicine visit.
• I can change my mind and stop using behavioral telemedicine at any time, including in the middle of a video visit. This will not make any difference to my right to ask for and receive health care.
• I will arrange a setting appropriate for a behavioral telemedicine session, including not driving a motor vehicle or potentially dangerous situation, or any situation deemed inappropriate by Sheila Harrington, LCSW.

Patient Consent To The Use of Telepsychiatry:

I hereby consent to engaging in behavioral telemedicine with Sheila Harrington, LCSW as part of my psychotherapy evaluation and treatment. I understand that "behavioral telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I have read and understand the information provided above regarding behavioral telemedicine.

Name of Patient:

First Name_____ Last Name_____

Signature of Patient or Representative: _____Date: _____

Witness: _____ Date: _____

Sheila Harrington, LCSW

Receipt and Acknowledgement of Notice of Privacy Practices

Patient Name: _____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Sheila Harrington, LCSW's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact:

Sheila Harrington, LCSW

8 Hillside Avenue, Suite 106

Montclair, New Jersey 07042

(973) 509-2370

_____

Signature of Patient **Date**

_____

Signature of Parent, Guardian or Personal Representative* **Date**

_____

** If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization. We may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.

Medical Emergencies. We may use or disclose your protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national

security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Sheila Harrington, LCSW:

• **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI.

• **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

• **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

• **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

• **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

• **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

• **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at ____Sheila Harrington, LCSW_____ or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**