CONSENT FOR TREATMENT AND HEALTH CARE OPERATIONS

I, _____________________________, hereby authorize, Wendell Wild, LCSW, (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, Wendell Wild, LCSW, (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).


______ 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 ______________________
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 hour notice is required to avoid a missed appointment or late cancellation fee.

The fee will only be waived if the appointment cancelled with less than 24 hours notice

1. is filled with another client
2. or the roads are closed due to a weather emergency.

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 our 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 hours notice. Also, when canceling a Monday appointment, you must phone by the appropriate time on Friday.

I also understand that I am responsible for this $70.00 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 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

3065 Southwestern Blvd, Suite 204
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.

_____________________________   _______________________
(Patient/Parent Signature)    (Date)

_____________________________
(Print name)