Client Information Form

Date of Initial Visit ___________________

Client's Name ____ Date of Birth _________________

If Client is a Child, Names of Parents ____

Address ____

City ____ State____________ Zip Code________________________

Phone # Home ______________________________________Work ____

Cell phone _________________________________ OK to Call? Y/N ______ OK to Leave Message Y/N _____

Email address ____

Marital Status _________________________________ Educational Background __________________________

Occupation ________________________________ Place of Employment __________________________________

Insurance Information:

Person Responsible for Payment ____

Relationship to Client ____

Date of Birth of Subscriber _________________________ Subscriber's Employer _________________________

Primary Insurance ____

Insurance Member ID#____ Group #________________________

Brief Description of Current Difficulties____

____

Referred By____

Have you had previous treatment from a counselor, psychologist, social worker or psychiatrist?

Y/N _______

If so, when? ______________________________________ Treated By _____________________________________

Are you currently on medications? Y/N_____ Please list all medications you are currently taking

____

MICHELLE CURTZE, MA, LPC, RYT-200 | 1373 WEST 6TH ST. ERIE, PA 16505 | (814) 454-2040

Notice of Privacy Practices

Your Rights Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information.
Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.
This means you may ask me not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure to your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from me.
Upon request, if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information.
If I deny your request for amendment, you have the right to file a statement of disagreement with me and I may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures I have made, if any, of your protected health information.

I reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to me or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **I will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003

I am required by law to maintain the privacy of, and provide individuals with, this notice of my legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask me (HIPPA Compliance Officer) in person or by phone at my main number.

Signature below is only an acknowledgement that you have received this Notice of Privacy Practices:

Print Name: ______________________________ Signature: ___________________________

Date: ________________________________

MICHELLE CURTZE, MA, LPC, RYT-200 | 1373 WEST 6TH ST. ERIE, PA 16505 | (814) 454-2040

Consent To Use And Disclose Your Health Information

This form is an agreement between you, ____ and me, Michelle Curtze. When I use the word "you" below, it can mean you, your child, a relative or other person if you have written his/her name here ____

When I evaluate, diagnose, treat or refer you, I will be collecting what the law calls Protected Healthcare Information (PHI) about you. I need to use this information here to decide on what treatment is best for you and to provide treatment to you or whoever needs it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to let me use your information here and to send it to others. The Notice of Privacy Practices explains in more detail your rights and how I can use and share your information. Please read it before you sign this consent form. If you do not sign the consent form, agreeing to what is in the NPP, I cannot treat you.

In the future, the way in which your information is used and shared may change, and therefore, the NPP may also change. If it is changed, you may call me at 814-454-2040 to obtain a copy of the new form.

If you are concerned about some of your information, you have the right to ask me not to use or share some of your information for treatment, payment or administrative purposes. You will need to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I will promise to do as you asked.

After you have signed this consent, you have the right to revoke it by writing a letter to me, telling me that you no longer consent. I will comply with your wishes about using or sharing your information from that time on, but will be unable to retrieve any information already shared.

____ _________________________
Signature of client or parent if client is under 14 years of age Date

____ _________________________
Printed name of client or parent Relationship to client

____ _________________________
Signature of Counselor Date NPP read by client

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Treatment Agreement Confidentiality

I respect the privilege of confidentiality and typically release information only upon obtaining your written permission to do so. For instance, upon the initial session, I routinely ask that you permit me to release information to insurance managed care providers in order to obtain authorization for visits and/or in order to receive payment. There are several exceptions to this rule of confidentiality. These exceptions include what is required by state law (for example: information regarding child abuse) and information indicating the immediate intent of the client to pertinent harm him/herself and/or a specifically named person. Consistent with my respect for life and human dignity, I will release pertinent information to the appropriate authorities in such cases. I am an independent clinician and no one has access to your chart or billing information. I reserve the right to have a HIPPA trained billing specialist handle your billing information, though that person will not have access to your complete chart. You have the right to access information from your chart which can be done in consultation with me. I feel that the trust given to me by a client is the core of the therapeutic process, and I provide therapeutic, not evaluative services. For this reason I will not participate or provide clinical information for any legal reason beyond that which I am mandated to comply with by law. You also have the right to acknowledge me, or not to acknowledge me in public. I have private voice mail for any messages that you may need to leave for me. Again, no one has access to my messages.

There may be times when I need to contact you at home or your place of employment to schedule or cancel an appointment. If I am unable to speak directly with you, may I leave a message? Please initial.

Home: Yes______ No______

Work: Yes______ No______

Cell: Yes______ No______

Cancellation Policy:
When appointments are scheduled, it is a period of time that has been set aside for the provision of quality psychological services, to an individual in need of those services. A missed appointment without **24 hour notice** reduces the time needed to offer available hours to other individuals in need and waiting for services. **You will be charged the current self-pay rate of $100.00 if you miss an appointment, or if you provide less than 24 hours notice.** In addition, missing 3 appointments without notice will result in you being discharged from this practice. I do understand emergencies, but I need to hear from you by phone. My voice mail does record the date and time of your message. **This charge is not reimbursable through insurance coverage.**

Please sign: ____

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Payment Authorization

I authorize Michelle M. Curtze, LPC to bill my insurance company for mental health counseling services that I received at her office at 1373 West 6th Street; **I agree to pay any co-pay and/or deductible payment at the time of service**.

Signature____ Date________________________________

If payment is out of network, I agree to pay the stated fee for mental health counseling services received from Michelle M. Curtze, LPC at her office at 1373 West 6th Street, at the time of service.

Signature____ Date_________________________________

I agree to give a 24 hour notice prior to canceling any appointments. **I agree to pay the current self-pay rate of $100.00 for an appointment not canceled with 24 hour notice or if I do not show.**

Signature____ Date__________________________________