Alden Mental Health
Counseling Wellness, PLLC

PHONE (716) 937-3300
FAX (716) 937-3304
ADDRESS 11901 Broadway St. Alden, NY 14004
INFO www.AldenCounseling.com

INTAKE INFORMATION

PATIENT'S NAME _____
(First) (Initial) (Last)

PARENTS OF MINOR _____

ADDRESS _____ CITY _____ STATE _____ ZIP_____

HOME PHONE _____ PATIENT'S BIRTHDAY _____

INSURANCE INFORMATION

INSURED'S NAME AND ADDRESS _____

INSURED'S DOB _____ INSURANCE COMPANY _____

INSURED'S EMPLOYER _____ WORK # _____

ID #_____ GROUP # _____

EMPLOYER'S ADDRESS _____

CONSENT FOR TREATMENT OF CHILDREN AND ADOLESCENTS: I / We consent that

_____ may be treated as a client(s) by ALDEN MENTAL HEALTH COUNSELING WELLNESS, PLLC. (Patients Name)

Signature(s) _____ Date _____

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information shared with our staff psychiatrist and b) information you and your child or children report about physical or sexual abuse; then, by New York State Law, I am obligated to report this information to the Department of Social Services, c) information shared with your insurance company to process your claims, d) where you sign a release to have specific information shared, e) if you provide information that informs me that you are in danger of harming yourself or others. If an emergency arises for which the client or their guardian feels immediate attention is necessary, the client or the guardian understands they are to contact the emergency services in the community for those services. Alden Mental Health Counseling Wellness, PLLC will follow those emergency services with standard counseling and support to the client or the client's family.

Signature(s) _____ Date _____

Financial / Insurance issues: Payment of services is due at the time of services rendered, unless you have made other arrangements with your therapist. **Please be advised that IF YOU DO NOT CONTACT US TO CANCEL your appointment with 24 hours notice, there will be a fee equivalent to the cost of your session.**

Signature(s) _____ Date _____

NOTICE OF PRIVACY PRACTICES

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, which may identify you and 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. 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.

For Payment. We may use or 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, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, 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 make disclosures of 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.

The following is a list of the categories of uses & disclosures permitted by HIPAA without authorization.

- Abuse & Neglect
- Emergencies
- National Security
- Judicial and Administrative Proceedings
- Law Enforcement
- Public Safety (Duty to Warn)

(continued on next page)

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- 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.

Verbal Permission. We may 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 your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to your therapist:

- **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 may be 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.
- **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.
- **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 healthcare 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, please contact us personally and discuss your concerns. If you are not satisfied with the outcome, you may contact 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.**

The effective date of this Notice is _____.

NOTICE OF PRIVACY PRACTICES

RECEIPT AND ACKNOWLEDGEMENT OF NOTICE

PATIENT / CLIENT NAME _____

DOB: _____ SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Alden Mental Health Counseling Wellness, PLLC's Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact my therapist.

_____
Signature of Patient / Client

_____
Signature or 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.):**

_____

_____

_____

❑ Patient / Client Refuses to Acknowledge Receipt:

_____ _____
Signature of Staff Member Date

HIPAA AUTHORIZATION FORM

I, _____ , whose date of birth is _____ ,
(Name) (Date of Birth)

authorize Alden Mental Health Counseling Wellness, PLLC to disclose to and / or obtain from

_____ the following information:
(Facility / Provider / School & Address)

Description of Information to be Disclosed
(Patient/Client should initial each item to be disclosed.)

___ Assessment
___ Diagnosis
___ Psychosocial Evaluation
___ Continuing Care Plan
___ Current Treatment Update
___ Treatment Plan or Summary
___ Presence/Participation in Treatment
___ Progress in Treatment
___ 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. If other purpose, please specify:

_____

_____

_____

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written

notification to _____ at the above address. I further understand that a

revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this authorization expires on _____ , or otherwise indicated:

_____

_____

_____

Conditions

I further understand that Alden Mental Health Counseling Wellness, PLLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:_____

_____

_____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information (PHI) that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections. Other types of information may be re-disclosed by the recipient of the information in the following circumstances:

_____

_____

I will be given a copy of this authorization for my records.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual. Attach appropriate documents (power of attorney, temporary orders, health care surrogate, etc.)

_____

_____

❑ Check here if the client refuses to sign authorization.

_____ _____

Signature of Staff Witness Date