

# Peg A. Foley MA Marriage & Family Therapist

## Client Information Form For Groups

Client's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Male       Female       Single       Married       Divorced       Widowed

Where would you like me to leave you messages?

Home       Work       Cell       E-mail       None

If there is an emergency at the office and we must cancel your appointment, where should we call?  Home       Work       Cell       E-mail       None

Are you currently in counseling elsewhere?  Yes  No

How were you referred to my office? If internet, please list the directory you used to locate my ad. \_\_\_\_\_

### AGREEMENT FOR THERAPY

I, \_\_\_\_\_

- Agree to receive therapeutic services provided by Peg A. Foley MA.
- I have read, understood, and signed the informed consent related to therapy and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both myself and my family.
- Furthermore, I understand that I am expected to be an active participant in this process.
- I acknowledge that I have received and understand the Notice of Privacy Practices for this office.
- My signature below means that I understand and agree with all of the points above.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

### **Credit Card Information**

Name on credit card: \_\_\_\_\_

Number: \_\_\_\_\_

CVS: \_\_\_\_\_ Exp Date: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### **HEALTH PROVIDER'S STATEMENT**

I have inquired to insure that the patient understood the above description of the limits on confidentiality.

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Health Provider's Signature

Date

### **HIPPA 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 it carefully. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

#### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your therapist and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your therapist's practice. These activities

include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Acknowledgement of Receipt of HIPPA Notice of Privacy Practices**

I acknowledge that I have received and understood the HIPPA Notice of Privacy Practices for this office:

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Client signature (parent or guardian if minor patient)                      Date

Consent for Use and Disclosure of Health Information:

I hereby permit and release Peg A. Foley MA to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, PPOs, managed care organizations, IPAs, or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions.

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Client signature (parent or guardian if minor patient)                      Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent