

Healthy Insights, Inc.
 5150 Linton Blvd., Suite 310, Delray Beach, FL 33484
 Phone: 561-498-8585 Fax: 561-499-8585

PATIENT REGISTRATION FORM

Date:			
Patient's Name:			
Address:	<i>Street:</i>		
	<i>City/Zip:</i>		
Phones:	<i>Home</i>	<i>Office</i>	<i>Cell</i>
Date of Birth:			
Email:			
Marital Status:			
Primary Care Physician:	<i>Name & Phone Number</i>	<i>May we contact this provider to coordinate care? YES NO</i>	
Psychiatrist (if applicable):	<i>Name & Phone Number</i>	<i>May we contact this provider to coordinate care? YES NO</i>	
Name & DOB of Insured : <i>(If different from patient)</i>	<i>Name :</i>	<i>Date of Birth:</i>	
Primary Problem:			
Medical Conditions:			
Significant Psychological and/or Medical History:			
Medications:			

CANCELLATION POLICY

Except in severe weather conditions or extreme emergencies, **24 hour notice is required for session cancellation.** Sessions that are cancelled late, and cannot be rescheduled during the same week, will incur a full session fee. Please sign below acknowledging your notification of this policy. (NOTE: Insurance companies do not pay providers for cancelled appointments)

Signature: _____

Date: _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize my psychologist to provide necessary clinical information requested by insurance companies to pay my psychologist directly. I understand that I am responsible for any charges not covered by my insurance policy.

Signature: _____

Date: _____

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PRACTICE POLICIES

We have found it best to have our practice policies clearly understood at the start of treatment. If you have any questions, please do not hesitate to ask us before initialing each policy.

SESSION TIME: Therapy sessions are 45 – 50 minutes long. These guidelines have been established by insurance companies. Any additional session time is provided at the discretion of the therapist.

INSURANCE COVERAGE: It is your responsibility to know and keep track of your insurance benefits (i.e., deductible, number of session per year, need for authorization, co-payments).

INSURANCE COVERAGE CHANGES: It is your responsibility to notify us immediately if your insurance company, benefits, or card changes. Changes to insurance may increase or decrease the amount of your co-payment. We will bill or credit you accordingly if this is the case.

BROKEN APPOINTMENTS: Consistent appointment attendance is necessary for optimal therapeutic benefit and good practice management. ***WE REQUIRE YOU TO GIVE US AT LEAST 24 HOUR NOTICE WHEN CANCELING AN APPOINTMENT.*** We set this appointment time aside for you, thereby making it unavailable to another patient. If 24 hour notice is not given, and we cannot reschedule your appointment during the same week, you will be responsible for a full session fee REGARDLESS of the reason for cancellation (*i.e., illness, car trouble, last minute meeting, no babysitter, etc*). ***THE CREDIT CARD ON FILE WILL BE USED FOR BROKEN APPOINTMENTS AND LATE CONCELLATIONS.***

CONFIDENTIALITY: Use of insurance may require us to disclose diagnosis and treatment focus, otherwise, issues discussed during psychotherapy sessions are confidential. Exceptions to this policy are when disclosure is legally mandated by law or when self-harm or injury to others appears possible. Appropriate steps will be taken to insure the safety of anyone at risk.

REPORTS: Requests for reports or other paperwork, other than normal billing paperwork, will be billed to you at a professional hourly rate.

RETURNED CHECKS: A \$25 fee will be charged for any check returned by the bank.

CO-PAYMENTS: You should be prepared to pay your co-payments at the time of the session. We accept cash, checks, Mastercard, Visa, Discover, and American Express.

Name: _____

Date: _____

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CREDIT CARD AUTHORIZATION FORM

We require a credit card to be kept on file in the event of late cancellations (less than 24 hours) or “no show” appointments. A full session fee according to your insurance policy will be charged.

NAME ON CARD: _____

TYPE OF CARD: (circle one) MC VISA AMEX DISC

CARD NUMBER: _____

EXPIRATION DATE: _____

SIGNATURE: _____

HEALTHY INSIGHTS, INC.
Caryn L. Goldberg, Ph.D.
Pamela N. Markham, Psy.D.
5150 Linton Blvd, Suite 310
Delray Beach, FL 33484
561-498-8585

HIPAA PRIVACY NOTICE

This notice describes how information about you may be used and disclosed and how you can get access to this information.

We are committed to protecting your privacy and that of your medical records. However, I may have to use and disclose medical information as outlined below:

For the purposes of providing psychotherapy.

Information may be shared among office staff and with other providers outside this office if they are involved in your treatment.

For the purpose of payment.

Information about you may be disclosed for billing and collection. This may involve an insurance company a family member, a collection agency, or any third party that may be involved in payment for your care.

For appointment reminders.

We may call you, speak to you or leave a message with someone or on an answering machine regarding your upcoming appointment.

For authorization of initial treatment or continuation of treatment.

We may disclose information to insurance companies, HMOs or managed care companies in order to obtain approval for treatment plans.

As required by law.

We must disclose information about you if required by law.

To avert a serious threat to health or safety.

We may disclose information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Workers' Compensation and disability.

We may release information about you to Workers' Compensation programs, disability insurers, or Social Security Administration. In certain instances, such information may be released to your employer.

Public health risks.

We may disclose information about you in cases of child abuse or neglect, adult abuse or neglect, domestic violence, and any potential risk.

Health oversight activities.

We may disclose information to a health oversight agency for activities authorized by law such as audit, investigations, inspections, and license.

Legal matters.

We may disclose information about you to attorneys, courts, or other agencies in response to a court order, warrant, summons, subpoena, discovery or request, or to assist in an investigation.

YOUR RIGHTS REGARDING INFORMATION ABOUT YOU

Right to inspect and copy.

You have the right to inspect and request a copy of your record as well as your billing record. You must submit a written request and pay for the cost of copying your records.

Right to amend.

If you feel that information contained in your record is incorrect or incomplete, you have the right to ask me to amend the information. You must submit a written request and provide a reason for your request.

Right to an accounting of disclosures.

You have the right to request, in writing, a list of the disclosures we made of information about you within a period not exceeding six years.

Right to request restrictions.

You have the right to request, in writing, a restriction or limitation on information we use or disclose about you.

Right to request confidential communication.

You have the right to request that I communicate with you about your psychological matters in a certain way and at a certain location.

Right to a paper copy of this notice.

We will provide you with a copy of this notice upon your request.

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NOTICE OF PRIVACY PRACTICE (HIPAA) PATIENT ACKNOWLEDGEMENT

I acknowledge receipt of a copy of Healthy Insights Inc.'s notice of Privacy Practice.

Patient's Name: _____

Signature: _____

Date: _____