Andrea DiFilippo, LICSW & Associates

REGISTRATION FORM

Today's Date:			
PATIENT INFORMATION			
Patient's last name:		First:	Middle:
Birth date:	Age:	Sex: M F	Marital Status: S M D Other
Address:			
Social Security no.:	Home phone no.:	Cell phone no.:	
Email:			Employer:
Medications:		PCP	
INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Please indicate primary insurance:			
Subscriber's name:	Birth date:	Subscriber's S.S. no.:	Employer:
Group no.:	Policy no.:	INS phone no.:	Co- Pay $
Patient's relationship to subscriber: Self Spouse Child Other			
Secondary Ins: (for Medicare ONLY)		Group no.:	Policy no.:
IN CASE OF EMERGENCY			
Name of Contact:		Relationship to patient:	Home phone no.: Work phone no.:
AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS			
I authorize the release of medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize and request my insurance company to pay the amount due on my medical care to: Andrea DiFilippo, LICSW & Associates.			
Patient/Guardian signature			Date

YOUR RIGHTS AS A CLIENT

Therapy is a relationship between people which works in part because of the clearly defined rights and responsibilities held by each party. A clear understanding of these rights and responsibilities helps to create the safety necessary to take risks. Additionally, you need to be aware of the legal limitation regarding these rights. Your therapist has corresponding responsibilities to you. What follows is a summary of these rights and responsibilities.

1. Confidentiality
   With the exceptions of the specific situations described below, you have the right to full confidentiality. Your therapist will not tell anyone outside of the practice what you have discussed, nor will she disclose that you are even a client in therapy, without your prior consent. Your privacy is protected both by law and by professional ethics. Your therapist may legally speak to another health care provider or a member of your family without your prior consent but will not do so unless the situation is an emergency. You may request that information be shared with whomever you choose, but you also can revoke that permission at any time.
   PLEASE NOTE: The following are legal exceptions to confidentiality. You will be informed, whenever possible, if your therapist is taking action due to the following conditions:

   (a) If there is a reason to believe you are a danger to yourself or others.
   (b) If there is a good reason to suspect or evidence of, abuse and/or neglect affecting children, elderly or disabled persons.
   (c) In response to a court order or where otherwise required by law.
   (d) To the extent necessary to make a claim on a delinquent account via a collection agency or small claims court.
   (e) To the extent necessary for emergency medical care to be rendered.

2. Record Keeping
   Brief records are kept stating that you have been in therapy. Topics discussed are noted. You have the right to review your records at any time and you have the right to request a copy of your records to be made available to any other health care provider. Such a disclosure requires a written request. Records are kept in a locked space or on a computer disc. These records cannot be accessed by anyone other than your therapist.
3. Messages
   If you need to reach your therapist between sessions, or in the case of an emergency, you have the right to a timely response. You may leave a message on your therapist's voicemail. If for some reason, your therapist is unreachable and your need for care is immediate, please contact your nearest emergency room. If your therapist plans to be out of the office for an extended period of time, she/he will advise of this in advance and will provide you with the name and telephone number of the therapist covering the practice.
4. Complaints
   If you are unhappy with your therapy, we hope that you will discuss this with your therapist so that she/he can respond to your concerns. Your criticism will be taken with care and respect. If you believe your therapist is unable or unwilling to listen, you may contact the National Association of Social Workers to file a complaint. You may also file a complaint with the Massachusetts Board of Registration.
   You have the right to considerate, respectful and safe care without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion or national origin. You have the right to ask questions of your therapist regarding your therapy and your therapist's training or experience. You have the right to request a referral to another therapist and you have the right to end your therapy at any time.

YOUR RESPONSIBILITIES AS A CLIENT

1. Appointments
   You are responsible for coming to your sessions on time and on the day scheduled. If you are late, your appointment may still need to end on time. The time scheduled for your session is scheduled for only you. For late cancellations and "No Shows", please see our policy below.
2. Closing Cases
   If you have not seen your therapist in 3 months and we have not heard from you to schedule another appointment, your case file will be closed, and you will no longer be considered as current client of the practice.

3. Cancellations and 'NO SHOW' Policy
   Cancellations of scheduled appointments must be communicated to our office at least 24 hours prior to the scheduled appointment time. For your convenience you may leave a message of cancellation on our voice mail system. "NO SHOW" appointments will be charged a **$75 FEE** and appointments not cancelled with 24 hours' notice will be charged a **$50 FEE**. Appointments are in high demand, and your early cancellation will allow another patient access to a session with their therapist.
   Patients who do not show up for their appointment or without a call to cancel will be considered as "NO SHOW". Patients who No Show three (3) or more times in a 12-month period, may be dismissed from the practice and they will be denied any future appointments. The Cancellation and" NO SHOW" fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with provider approval.
4. Fees
   You are responsible for paying fees/copays at time of services. Initial sessions are 175.00 (50 mins), follow up session are 150.00 (50mins). Phone calls and written letters will be billed by our hourly fee and are not billable to insurance companies. If your therapist is required to provide courtroom documentation or verbal testimonial, the fee is 250.00 per hour. Balances past 90 days are subject to collection agencies and small claims court, including fees to secure payment.

PRINT NAME: _____
(CLIENT/GUARDIAN)

SIGNATURE: _____
(CLIENT/GUARDIAN)

DATE: ____ / ____/___

STATEMENT REGARDING PRIVATE HEALTH INFORMATION

It is the intent of this office to be in compliance with the privacy standards for Private Health Information (PHI) covered under Heath Insurance Portability and Accountability Act (HIPPA).

1. I understand that I have the right to request that certain information be excluded from my record unless the information is related to my diagnosis or is related to one of the exceptions listed on "Your Rights As A Client"
2. I understand that I have the right to amend information but not expunge (erase) information from my record.
3. I understand that I have the right to inspect and/or receive a copy of my Private Health Information (PHI) i.e. record unless it is legally determined that it would adversely affect my well-being, or I am a minor. My request must be fulfilled by this office within 60 days of my written request. There will be a charge for copies.
4. As additional HIPAA regulations are mandated and clarified, this office will be altering its policies and procedures to be in compliance.
5. If this office is found to be in violation of the Primary Standards put forth in HIPAA, I am urged to speak with my therapist and if not resolved, I have a righty to file a formal complaint with the Office of Civil Liberties.

I have read the above privacy standards for private health information covered under HIPPA.

SIGNATURE: _____
(CLIENT/GUARDIAN)

DATE: ____ / ____/___