Diane Abdo, Psy.D., PA

PATIENT INFORMATION FORM AND TREATMENT AGREEMENT
CONFIDENTIAL

Name: _____ **Date:** _____

HomeAddress: _____

_____

Contact Home: _____ **Cell:** _____

Email: _____ **Work :** _____

Marital Status: _____ **Occupation**: _____

Social Security Number: _____ **Date of Birth**: _____

Emergency Contact: Name: _____ **Phone**: _____

General Reason for Contacting Dr.Abdo: _____

_____

Is this initial visit an emergency? _____ **Are you suicidal?** _____

Referred by: _____

Primary Care Physician:

Name: _____ **Phone**: _____

Address: _____

(Please circle one**) I AGREE/ DO NOT AGREE** to allow Dr. Abdo to discuss any pertinent confidential information regarding my case with my primary care physician. **Initial**_____

Name of Service Provider	**Date Seen**:	**Reason:**

I _____ hereby authorize Diane Abdo, Psy.D.
Client name

to speak share and discuss with the above mentioned Attending or Primary Care Physician all pertinent and professional information pertaining to me. In consideration of this consent I hereby release the above parties from any legal liability resulting from the release of information.

Signature: _____ **Date:** _____

Allergies: _____

Physical Impairments: _____

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(561) 393-5363, tel (561) 361-6706, fax

Current Psychiatrist:

Name: _____ **Phone:** _____

Address: _____

Please circle one) **I AGREE/ DO NOT AGREE** to allow Dr. Abdo to share all pertinent confidential information regarding my case with my psychiatrist.

Medications Currently Being Taken:

Medication Name:	**Dosage**	**Prescribing Doctor**:

FINANCIAL INFORMATION AND AGREEMENT:

Name of Party Responsible for Payment: _____

If other than patient, relationship to patient : _____

Address: _____

Phone Home: _____ **Cell**: _____

Social Security Number of Financially Responsible Party _____

In consideration of the services provided by Diane Abdo, Psy.D., P.A., I, the undersigned, agree as follows: I agree to take financial responsibility for all charges and fees incurred in connection with services provided by Diane Abdo, Psy.D. for myself and/or my dependent(s). I hereby acknowledge and accept the fee information that has been provided to me regarding the services to be performed. **My fee per session is _____.**

I understand and agree that if I fail to provide Dr. Abdo with 24 hours advance notice of cancellation of my appointment, or if I fail to appear for a scheduled appointment, I am responsible for payment of the full fee for the missed session. I understand that the full session fee for the missed appointment must be paid at the start of the next session.

I accept that I am financially responsible for all charges for psychological services performed by Diane Abdo, Psy.D., whether or not my insurance company (traditional, managed care, Medicare and/or secondary policy company) pays them. In the event of non-payment or partial payment by my insurance company or other responsible party (for Dr. Abdo's services), or in the event that my account is placed for collection, I agree to pay, in addition to any outstanding balance due, all costs for collecting the balance due, and/or all court costs as well as any attorney fees. **Initial_____**

I accept that any process of securing or recovering payment necessitates the sharing of information about me by Dr. Abdo or her office staff to the appropriate organization representative. I understand and agree that payment is to be made at the time of service. Each session will normally last 45 minutes. **Initial_____**

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I acknowledge and agree to responsibility for payment of psychological services provided to: (patient name) _____by Diane Abdo, Psy.D.

_____

Signature of Financially Responsible Party **Date**

I understand and accept that, although Dr. Abdo is committed to the helping process with her clients, it is impossible for her to be available 24 hours a day. If an emergency arises in which I fear my own suicidal impulse, I must alert Dr. Abdo (or any psychologist covering her practice if she is unavailable) and call 911 or go to a local hospital emergency room for immediate care by qualified health care professionals.

Initial_____

CONSENT TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Your right of confidentiality as a patient is protected by Federal confidentiality rules. Federal rules prohibit disclosure of any confidential information unless there is written consent. By signing below, you are recognizing, understanding and agreeing to the following confidentiality policies:

A. If you rely on health insurance to cover the services provided, your diagnosis(es), psychological process, treatment and prognosis must be disclosed and discussed with your health insurance provider (in order to obtain authorizations for treatment sessions and payment by the insurer).
B. Information in your records will not be released to any requester or insurer without your written authorization, unless an exceptional situation exists (see C below). In the absence of such a situation, information cannot be released based on your verbal permission alone, which will therefore necessitate your presence in my office to sign appropriate and required information release forms.
C. Your privacy may be breached without your expressed consent only in the following circumstances:
    1. Imminent risk of danger to yourself or named other(s).
    2. Failure to perform the skills of daily living, where health and/or safety concerns are paramount.
    3. Emergency medical/mental health situation, in order to save your life or enable
    4. the appropriate care to be administered to you.
    5. Cases of suspected child, dependent or elder abuse.
    6. Valid subpoena of your records for a legal proceeding or the requirement (by subpoena) of Dr. Abdo to testify in court regarding your case.
    7. Sharing of information regarding treatment of a minor with the parent (s), legal guardian(s) or legal authorities (with authority over the minor patient).

As a condition of providing treatment to you, the provider may request your consent to use and disclose protected health information about you to carry out treatment, payment and health care operations. You may revoke this consent at any time by notifying the provider in writing, except to the extent that the provider has taken action and reliance on your consent.

Please refer to the Notice of Privacy Practices for Protected Health Information ("Privacy Notice") for a more complete description of the uses and disclosures that the provider may use of your protected health information.

You have the right to review the Privacy Notice prior to signing this consent. The provider has reserved the right to change its privacy practices described in this Privacy Notice.

In accordance with law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice. You have the right to request that the provider restrict the manner in which your protected health

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information is used or disclosed to carry out treatment, payment, or health care operations. The provider is not required, however, to agree to such requested restrictions. If, however, the provider agrees to the requested restriction, the provider will honor the request and it will be binding. **Initial**_____

I hereby consent to the use and disclosure by my provider, its workforce, and its business associates of my protected health information for purposes of treatment, payment and health care operations.

** I acknowledge that I have received a copy of the Notice of Privacy Practices. **Initial**_____

By signing below, I confirm understanding of and compliance with all policies and practices of this office herein explained.

Client Signature **Date**

Client Signature (Spouse) **Date**

Signature of Parent/Legal Guardian **Date**

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