CAROLINE BUCKMAN, MSW, LCSW

To my clients:

I am looking forward to our work together. I invite you to take an active part in guiding your care here by observing the following:

1. Our sessions are 45-55 minutes long, as approved by your insurance company or as contracted between us. There are times when we will need to go beyond this time to gain closure on a piece of work. It is helpful if you enter the session with your own goals in mind, expressed early on.
2. Please be prompt, as I will also attempt to be. There are occasional factors (handling an emergency, illness) which may cause me to be a bit late, but I will try to keep that to a minimum.
3. If you need to cancel, please do so at least 24 hours in advance (preferably 48 hours). My policy is to charge a fee if notice is not given. If I must cancel without affording you 24 hours notice, I will offer you an extra session, without fee. In the case of a true illness or emergency, this does not apply for either party.
4. Payment is expected at the time of service, unless other arrangements have been made. It is up to each client to bring complete insurance information, including any required preauthorization number, to our first session, in order for me to participate in your insurance system. If this information is not provided, you will be charged as a self-pay client.
5. This office is required by law to report child or adult abuse. Confidentiality does not apply in cases of life-threatening emergencies.
6. Because texting does not meet the requirements of the HIPPA law, please contact me by voicemail or e-mail.

I understand and agree to the above.

Signed: ____Date: ___________________

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND CLAIM PAYMENT INFORMATION

I hereby authorize the above clinician to release any information regarding services rendered by her and allow a photocopy of my signature to be used to file insurance.

Signed: ____Date: ___________________

Patient (parent or guardian, if a minor)

I hereby authorize and direct my insurer to issue payment check(s) for benefits due me for services rendered by the above named clinician to be made directly to her regardless of my insurance benefits, if any. I understand that I am financially responsible for the fees for services rendered.

Signed: ____ Date: ___________________

Responsible person (policy owner, insured)

CAROLINE BUCKMAN, MSW, LCSW

Patient name: ____ Sex: M / F

Patient address: ____

____

DOB :____________________ Marital status: ____________________

Patient SS#: _______________________________

Custodial parent: _____________________________ (if patient is minor under the age of 18)

Custodial parent SS#: _____________________________

Patient phone: (Home) _____________________________ Patient Fax: _______________

(Cell) ____________________________ May we contact you at all

(Work) _____________________________ these phone numbers? _______

Emergency contact:______________________________ Phone: _____________

Prior treatment? If yes, where? ____

Who referred you? _________________________________

Reason for being seen: ____

____

INSURANCE INFORMATION

Policy holder name: ____

Policy holder DOB: __________________Policy Holder SS #:________________________

Relationship to patient: ____

Policy holder address: ____

____

Policy holder employer: ____

Employer address: ____

Employer phone number:______________________

Insurance company name: ____

Policy ID number: __________________________ Group number: ________________________

Provider inquiry number: ____

SECONDARY INSURANCE

Policy holder name: ____ DOB: ____________

Policy holder SS #: __________________________________

Relationship to patient: __________________ Mental Health Carrier: _______________________

Insurance company name: _______________________ Provider inquiry #: __________________

ID#: ______________________________ Group#: _______________________________________

Policy holder employer: ____

INSURANCE ISSUES AND LATE CANCELLATIONS

We are asking clients to assist in assuring that business issues flow smoothly. Please be aware that we cannot know which companies provide which mental health benefits, and that each client should research her/his own policy. You will want to know about your own policy. You will want to know about your own deductible. It is up to the client to acquire the initial preauthorization from the insurer.

Please keep up with this, yourselves, so that you are not surprised by any unpaid claims. Our office will be happy to submit a claim for any visit, but we often do not hear from insurance companies for 60-90 days after the bill has been submitted. Therefore, we cannot notify you in advance that your insurance company has not agreed to pay. We will assist as much as possible, but, in the end, you are responsible for securing correct information from your insurer, and for making sure that payment is made to this office.

Because this office has set aside almost a full hour for your session, we are acknowledging that this one-on-one time is valuable. We cannot logistically fill this space with another client, without 24 (preferably 48) hours notice. Therefore, we ask that you give careful consideration to cancelling late or failing to remember when you are scheduled. You will be charged for late cancellations or no shows.

Please acknowledge your understanding of these policies by signing below:

Signed: ____

Date: _________________________________

CAROLINE BUCKMAN, MSW, LCSW

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of my health care, Caroline Buckman, MSW, LCSW and affiliates originate and maintain health records. The health records describe my health history, symptoms, examination, and test results, diagnoses, treatment, and plans for the care or treatment. I understand that this information serves as:

-A basis for planning my care and treatment

-A means of communication among the many health professionals who contribute to my care.

-A source of information for applying my diagnosis and medical treatment information to my bill

-A means by which a third-party payer (i.e. insurance co.) can verify that services bills were actually provided

-And a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

Caroline Buckman, MSW, LCSW and affiliates' Notice of Privacy Practices gives a more complete description of how my health information may be used or disclosed. The notice also explains my rights regarding my personal health information, including the right to access my own records and the right to request restrictions as to how my health information is used or disclosed.

I understand it is my responsibility to notify Caroline Buckman, MSW, LCSW and affiliates regarding any restrictions concerning disclosure of health information regarding this or any subsequent visit.

I have been provided with a Notice of Privacy Practices and have been given the opportunity to review this information.

Signature : ____________________________________ Date: __________________