# CONTACT PERMISSION FORM

**PLEASE PROVIDE US WITH SOME INSTRUCTIONS ABOUT HOW WE SHOULD CONTACT YOU:**

I understand that Union Street Counseling Services will need to communicate to me appointment and other confidential information on behalf of my private practice provider. In providing Union Street Counseling Services with a confidential contact number and or giving permission to leave a message, I agree that such confidential information may be transmitted in that fashion without further notice to me, and hereby authorize Union Street Counseling Services to do so.

I understand that if my confidential home, cellular or other telephone number should change or becomes inoperative at any time, or if I wish to revoke numbers, it shall be my obligation to notify Union Street Counseling Services in writing of such change.

In the absence of such notice, Union Street Counseling Services shall have no obligation to obtain alternative home, cellular or other telephone number for me or to refrain from leaving a message, nor shall it have any liability for transmittal of the confidential information.

Mailing Address:_____

_____

Email Address:_____

PRIMARY TELEPHONE NUMBER:_____

PERMISSION TO LEAVE MESSAGE ON THIS NUMBER:_____

PERMISSION TO SEND TEXT MESSAGES TO THIS NUMBER:_____

**TEXT REMINDERS CAN ONLY BE SENT TO A CELLULAR NUMBER AND PATIENT MAY BE SUBJECT TO FEE PER CELLULAR CARRIER*

SECONDARY TELEPHONE NUMBER:_____

PERMISSION TO LEAVE MESSAGE ON THIS NUMBER:_____

_____

Patient or Legal Guardian Signature

_____ _____

Print Name Relation to Patient

_____

Date

**1311 Union Street**
**Schenectady, NY 12308**
**518-374-6263**

**5 Hemphill Place, Suite 121**
**Malta, NY 12020**
**518-289-5072**

***All Providers are in Private Practice***

# FINANCIAL POLICY: AGREEMENT FOR PAYMENT

PLEASE READ AND ***INITIAL*** EACH LINE BELOW ACKNOWLEDGING YOU HAVE READ ALL POLICIES

____ **NO SHOW:** Union Street Counseling Services (USCS), on behalf of your provider(s) cannot bill the insurance company for these charges, but is permitted by insurance companies to bill the patient. Your provider(s) kindly ask for 24 hour notice if you are unable to come to an appointment. Notifying USCS 24 hours in advance allows us to offer the appointment time to others. Failure to show up for an appointment without notification is subject to a **NO SHOW** charge, currently **$40**. **Please note: reminder calls/texts are done as a courtesy, it is the patient's responsibility to keep all appointments. NO SHOW fees must be paid in order**

_____ **COPAYMENTS** are due at the time of the office visit. Failure to pay your copay will result in cancellation of your appointment.

_____ **DEDUCTIBLE POLICY PLANS** require a down payment of $50 dollars due at the time of the office visit. Failure to pay the down payment will result in cancellation of your appointment

_____ **INSURANCE BILLING:** I hereby give permission to my provider(s) to bill my insurance for procedures as deemed necessary in the diagnosis and/or treatment of my condition. I hereby assign to my provider(s) all benefits provided by my insurance company policy or policies for care.

_____ **CHANGE INSURANCE PLANS:** I understand that my provider(s) may not be credentialed with my new insurance carrier. It is my responsibility to inquire with the insurance carrier to verify if my current provider(s) accept my insurance policy. If I do not give prior notice to USCS, I understand that I will be responsible for payment to my provider(s) if my insurance will not cover visits prior to the date that I provided USCS with my new insurance policy.

_____ **RETURNED CHECK FEE:** Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $35 fee per check returned. After the first returned check, check payments will no longer be accepted.

_____ **PAST DUE ACCOUNTS**: Accounts that are past due greater than 90 days are subject to being referred to a collection agency as well as a $50 late fee charge. I understand that I am financially responsible for any balance due on my account that my insurance does not cover. I agree to reimburse USCS the fees of any collection agency, which will be added to the account at the time it is placed with an agency for collections and be based on a percentage at a maximum of 30% of the debt, and all reasonable costs and expenses, including reasonable attorney fees, incurred in such a collection effort. I also understand that my provider(s) can cancel appointments and/or discharge me as a patient from their practice for balances greater than 90 days.

**PRINT NAME:** _____

**RESPONSIBLE PARTY SIGNATURE:** _____

**PATIENT NAME (IF DIFFERENT FROM RESPONSIBLE PARTY):**_____

**DATE:**_____

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**NOTICE OF CURRENT INSURANCE**

To ensure that your current insurance is being billed, please complete the following. Failure to provide your current insurance will delay the billing process and may make you financially liable for your appointments. Providers are not Fee for Service Medicaid or Medicare providers. If Medicaid or Medicare is the primary insurance, the patient must be self-pay.

**Primary Insurance**

| | |
|---|---|
| Insurance Carrier/ Company: | |
| Policy Number: | Group Number: |
| Effective Date: / / | Policy Holder/ Subscriber Name: |
| Policy Holder/ Subscriber Address: | |
| Policy Holder Date of Birth: / / | Policy Holder Phone Number: |
| Policy Holder Relation to Patient: *Self* *Mother* *Father* *Spouse* *Child* *Other:* | |

**Secondary Insurance**

| | |
|---|---|
| Insurance Carrier/ Company: | |
| Policy Number: | Group Number: |
| Effective Date: / / | Policy Holder/ Subscriber Name: |
| Policy Holder/ Subscriber Address: | |
| Policy Holder Date of Birth: / / | Policy Holder Phone Number: |
| Policy Holder Relation to Patient: *Self* *Mother* *Father* *Spouse* *Child* *Other:* | |

**Self-Pay**

| | |
|---|---|
| Initial this box if you maintain that you are a self-pay patient. | |

Patient Name_____ Date of Birth_____

Responsible Party Name:_____

Patient/Responsible Party Signature_____ Date_____

# HIPAA

## HEATH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

HIPAA requires that your Provider(s) provide you with a Notice of Privacy Practices for use and disclosure of Patient Health Information (PHI) for treatment, payment, and health care operations. The Notice, explains HIPAA and its application to your personal health information. The law requires that we obtain your signature acknowledging that we have provided you with this information.

**Patient Information Protection Policy:** Your Provider utilizes a HIPAA compliant medical records storage system.

Your Provider:

A. Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Provider's legal duties and privacy practices with respect to your PHI.
B. Under the privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
C. Is required to abide by the terms of this Privacy Notice.
D. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
E. Will distribute any revised Privacy Notice to you prior to implementation.
F. Will not retaliate against you for filing a complaint.

### EFFECTIVE DATE

This Notice is in effect as of 01/01/2020

### PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

**PRINT NAME:**_____

**RESPONSIBLE PARTY SIGNATURE:**_____

**PATIENT NAME (IF DIFFERENT FROM RESPONSIBLE PARTY):**_____

**DATE:**_____

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# LIMITS OF CONFIDENTIALITY

In the course of the professional relationship, a practitioner may be called upon to discuss information relating to the case or to transfer records. The limits of confidentiality are broadly included in the following principles:

1. No information about the patient will be transferred to anyone else without the expressed permission of the patient. This must be done in writing as well as by verbal agreement.
2. Where the patient is a minor, every effort will be made to gain the minor's permission first and then the permission of the guardian or parent
3. If issues of sexual abuse of the patient emerge, it is the practitioners' responsibility to convince the patient to report this in the approbate manner specified by State statute. In the event that the patient refuses this permission, the practitioner will make the report over the patient's objection.
4. It is possible that at future times, various organizations (State entities, graduate schools, high-security government agencies, etc…,) may request information concerning the services rendered onto the patient. This information will be forwarded only with the written consent of the patient.
5. No electronic recording of any contacts or interviews will be made without specific written permission from the patient.

_____

Patient Printed Name

_____ _____

Patient Signature Date

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