TRUE NORTH
LYNN M. EDGERLY, LCSW-R
499 Glen Street, Glens Falls, NY 12801
Phone : (518) 798-9187 Fax: (518)223-0567

PATIENT INFORMATION

NAME: _____ DOB: _____

ADDRESS: _____

HOME PH.: _____ CELL: _____ WORK: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ Employer: _____

Insured's Name _____ Insured's DOB ___/___/____

Insured's Address _____

Insured's ID # _____ Group # _____

SECONDARY INSURANCE: _____ X ___(if not applicable)

Insurance Company: _____ Employer: _____

Insured's Name: _____ Insured's DOB ___/___/__

Insurance ID # _____ Group # _____

PATIENT SIGNATURE _____ **DATE:** _____

RESPONSIBLE PARTY SIGNATURE _____

Copay _____ Deductible _____

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CONSENT FOR TREATMENT

I, _____, will be receiving psychotherapy services from Lynn M. Edgerly, LCSW-R. These services will be confidential in nature with a few exceptions:

- As a mandated reporter, if there is an allegation of child or elder abuse or neglect it will be necessary for me to share pertinent information with the proper authorities.
- If there is an expressed intention to harm yourself or someone else, pertinent information would be shared with proper authorities to prevent such harm.
- Whenever permission has been granted in writing by you or your parent, as applicable, information may be shared with the identified entity.
- Information may be released to third party payers, such as your insurance company's carve-out payment vendor, for the purposes of receiving payment for services. This information will be limited to the information relevant to receive payment.

Lynn M. Edgerly can be reached at her office during normal business hours at 499 Glen Street, Glens Falls, NY, (518) 798-9187. Please leave a message with the secretary or on her confidential voicemail system. She will do her best to return phone calls in a timely manner. However, in the event of an emergency, call 911 or go to your nearest emergency room.

You may also consider calling one of the following resources:

Child Protective Hotline:	800-635-1522
Hopeline:	800-784-2433
NY Domestic Violence Hotline:	800-942-6906
Rape/Sexual Violence Hotline:	800-656-4673
Suicide and Crisis Hotline (Albany):	689-4673

The information contained in this document, limitations to confidentially and contact information has been reviewed. I understand that if I have additional questions or concerns regarding these matters, I will ask that they be addressed.

_____ _____
Signature of Patient (12 years of age and older) Date

_____ _____
Signature of Parent/Legal Guardian Date

_____
Printed Name of Patient

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TREATMENT AGREEMENT

Insurance Coverage is based on the insurance company's determination of "medical necessity". While many companies provide "preauthorization" for services, this does not guarantee that they will reimburse for your treatment.

By signing this agreement, I understand that any portion of counseling services that are not covered under my insurance policy is my direct responsibility and is to be paid in full. I will bill the insurance company for any predeterrmined authorized services. If your insurance policy or information should change at any time, it is your responsibility to provide our office with the new information so that authorization for services can be obtained. If you fail to notify our office and/or provide your new policy information you will be liable for any uncovered services.

CANCELLATION POLICY

If you are unable to attend a scheduled appointment, 24 hours notice must be provided. You may call the office and leave a message 24 hours a day and seven days per week. Reminder calls are provided as a courtesy only and failure to receive a reminder call does not excuse a missed All appointment that are not cancelled within 24 hours prior to the scheduled time will incur a $60 fee which will be the responsibility of the client. This fee can be waived if the client is able to reschedule within the same business week. If a client account accrues charges at/or in excess of $120 no further appointments will be scheduled until the balance is paid in full. (FEES RESULTING FROM FAILURE TO ATTEND A SCHEDULED APPOINTMENT ARE NOT COVERED BY INSURANCE COMPANIES, THEY ARE THE RESPONSIBILITY OF THE CLIENT) .

EMERGENCY/CRISIS

In the event that a crisis develops outside of normal business hours and you are unable to reach me, please call Glens Falls Hospital emergency Room or 911.

Patient or Parent Signature _____

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Policy for Legal Involvement

I agree that the role of Lynn M. Edgerly, LCSW-R is limited to providing treatment and I will not involve her in any legal dispute, especially a dispute concerning custody or custody arrangements.

I also agree to instruct my attorneys not to subpoena Lynn M. Edgerly, LCSW-R or to refer in any court filings to anything she has said or done.

If there is a court appointed evaluator, and if appropriate releases are signed, and a court order is provided, Lynn M. Edgerly, LCSW-R will provide general information related to my treatment which will not include recommendations concerning custody or custody arrangements.

If for any reason Lynn M. Edgerly is required to appear as a witness, the party responsible for her participation agrees to reimburse her at the rate of $220 per hour for time spent traveling, preparing reports, testifying,,being in attendance , and any court related costs. A retainer fee of $1,000 will be due before the required court appearance, and costs will be deducted from this fee and applied towards the total balance due resulting in a court appearance.

ADMINISTRATIVE FEES

RECORD REQUESTS:	Seventy-five cents per page plus postage.
TREATMENT SUMMARY;	$40.
CLINICAL REPORTS;	$200
PHONE CALLS;	Phone conversations will be billed at a rate of $20 per 15 minutes, and will be pro-rated for time exceeding 15 minutes.

I, _____ have read and understand the above practice policies and agree to the terms.

Signature_____ Date_____

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.
Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
Research. PHI may only be disclosed after a special approval process or with your authorization.
Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.
Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.
With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Sarah Lockhart-Palladino, LCSW-R:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, LYNN Edgerly LCSW-R or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013.