Dr. David J. Abrams, Psy.D. MSCP, P.A.

Patient Name:_____

Gender:_____**Age:** _____**Marital Status**_____

Date of Birth_____**Phone** _____

Address:_____

City_____**State**_____**Zip Code**_____

Primary Insurance Carrier_____

Name of Subscriber_____Effective Date_____

ID#_____Group #_____

Secondary Insurance Carrier_____Effective Date_____

ID#_____Group#_____

I understand that I cancel a scheduled appointment at least 24 hours prior to that time or I will charged $25.00 for that visit.

_____ _____

Signature of Responsible Party **Date**

NOTICE OF PRIVACY PRACTICES

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or *disclose your* protected health information (PHI), *for treatment, payment, and health care operations purposes with your consent.* The following definitions will help clarify these terms:

- "***PHI***" refers information in your health record that could identify you.
- "***Treatment, Payment and Health Care Operations***"

  Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

  Payment is when I obtain payment or reimbursement for your healthcare.

  Health Care Operations are activities that relate to the performance and operation of my practice. Examples are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "***Use***" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "***Disclosure***" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Your Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is **written permission** above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your progress notes or written psychological test report.

You may revoke all such authorizations (of PHI or progress notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse**: If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law **requires** that I report such knowledge or suspicion to the Florida Department of Child and Family Services.

- **Adult and Domestic Abuse**: If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am **required** by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

- **Health Oversight**: If a complaint is filed against me with the Florida Department of Health on behalf of the Board of Psychology, the Department has the authority to subpoena confidential mental health information from me relevant to that complaint.

- **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me

that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety**: When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

- **Worker's Compensation**: If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am **not** required to agree to a restriction you request.

- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.

- ***Right to Amend*** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the request process.

- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss the details of the accounting process with you.

- ***Right to a Paper Copy*** – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. This notice is in effect as of April 14, 2003.

- I may change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- Revised policies and procedures will be available in my office.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, or have other concerns about your privacy rights, you may contact

David Abrams, Psy.D.
561-706-3646

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to:

David Abrams, Psy. D
950 North Congress Avenue Ste. J230
Boynton Beach, FL 33426

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The appropriate address will be provided upon request. You have specific rights under the Privacy Rule. Filing a complaint will not affect the services you receive from me.

VI. Effective Restrictions and Changes to Privacy Policy

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail.

Acknowledgment that you have received the (HIPAA) notice of privacy practices to protect the privacy of your health information

Notice of Privacy Practices contains information about the following:
How your PHI may be used and disclosed for treatment, payment and health care operations.
Which uses and disclosures require authorization from you and which do not.
How you may revoke an authorization you have made.
Certain rights you must restrict use and disclosure of PHI, to receive confidential communications by alternative means,
and at alternative locations, to inspect, copy, and amend your records, and to have an accounting of disclosures.
My duties to protect the privacy of your PHI, my right to change policies in the Notice, and how I will inform you Of changes.
Restrictions you or I might place on the use and disclosure of your PHI.
How you can file a complaint about suspected violations of your privacy rights or about decisions regarding access to your
PHI.

Your signature below indicates that you have reviewed and understood the Notice of Privacy Practice

_____ _____

Patient or Guardian Signature Date

Patient Acknowledgement of Receiving the Notice of Privacy Practices

I understand that as part of my health care, David J. Abrams, Psy.D., originates and maintains electronic records describing my health history, symptoms, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment.

A source of information for applying my diagnosis and other information to my bill.

A means by which third-party payors can verify that services billed were actually provided.

A tool for routine healthcare operations such as assessing quality and reviewing the competence of health-care professionals.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices for Dr. David J. Abrams.

_____

Patient's Signature Date

David J. Abrams, Psy. D., MSCP
LicensedPsychologist P 6554

OFFICE POLICIES and INFORMED CONSENT

Appointments

Therapy sessions are typically 45-50 minutes. Please be on time for your appointment as this hour is specifically reserved for you. I cannot continue past the time allotted for you as this will run into my next patient's reserved time. You will not receive a reminder phone call about appointments. If you need to cancel your appointment please leave a message on voicemail or via text within 24 hours before your appointment. You may be charged a no-show fee of $50 if you miss your appointment. If an emergency arises after office hours, please call 911 or go to your local emergency room.

Confidentiality

Your therapeutic relationship is confidential. Records or information about your therapy will not be released without your written permission. However, there are several legal limitations to confidentiality. If I believe that you pose a threat to your life or the life of another person, I am legally responsible for taking measures to prevent such action. This may include contacting appropriate authorities. In addition, if there is reason to believe that child and elder abuse/neglect is occurring, I am legally obligated to report this to the appropriate authorities. This is for protection and for that of your family. Other information will be released to specific people only with your written authorization.

Social Media Policy and Texting

I do not accept friend requests from current or former patients on any social networking site. Engaging patients as friends or contacts on these sites can compromise your confidentiality and respective privacy. It may also blur the boundaries of the therapeutic relationship. In this regard, I cannot read either texts or emails of a clinical nature outside of the therapy hour (except for emergencies).

I understand and agree to these items and give Dr. Abrams permission to treat and/or evaluate me.

_____

_____

Patient print and signature **Date**
Patient (Print)

PhyBill
physician billing & collections

MEMO

Phone: 954.366.2700 **Date:** 12/15/2020

Re: Annual Update Form 2021

Please fill out this form and return to office via Fax 954.944.0308 or e-mail to us at, Billing@Phybill.com.

2021 Medicare Deductible Choices

1. ❒ Do not hold claims, invoice deductible to patient/responsible party asap.
2. ❒ Do not hold claims, I will deal with patients directly.
3. ❒ Hold claims until: _____, then release all.
4. ❒ Call for verification and release claims when deductible has been met.
   - ❒ Call once per month at $.1.65/call beginning:_____
   - ❒ Call twice per month at $.1.65/call beginning:_____

2021 Patient Statement Choices:

We do not charge a fee to prepare your patient statements. We can send them to you as a PDF file at no charge. We do charge a fee, $.65 each, if you want us to print them to paper. If you want us to print, insert into an envelope, and mail to the patient/responsible party, our fee is now $ 1.65 for each page. Our mailed statements include a return mailer (not postage paid) for your patients to use, very easy and professional looking.

1. ❑ Print and send to me @ $.65.
2. ❑ Print, insert and mail to patient/responsible party @ $ 1.65 per page.
3. ❑ Print to PDF files and e-mail to me for further distribution.
4. ❑ I will obtain statements myself from www/phybill.com.

Please update information: ❑ No Change

Mail address:			
E-mail address:			
Phone #'s:	Office:	Cell:	Home:
Other:			
Contact:			

HIPAA Use of Patient Names:

We will not use the patient name or any other individually identifiable information on e-mails to you or any other person or entity. Sometimes it is necessary to refer to a particular pt. when communicating via e-mail, so please choose an option.

❑ I give my permission to abbreviate the patient name, i.e.: "aldurxxx" (Alan Duretz).
❑ Do not abbreviate or otherwise refer to a patient name in any e-mail, except only as a secure, encrypted attachment.

Certification and authorization:

Please Sign Here:_____Print Last Name: _____