NEW PATIENT REGISTRATION FORM

Name _____ Sex _____

Address _____ Age _____
_____ DOB _____
_____

Home Phone _____ Work _____ Cell _____

E Mail address _____

Parents' Name (if patient is a minor) _____

Marital Status _____ Spouse's Name _____

Referred by _____

Reason for Referral

_____
_____
_____
_____
_____
_____

Current Medications

_____
_____
_____
_____

Emergency Contact Information:

Name _____ Relationship _____
Phone _____

Insurance Information received Yes _____ No _____

_____ _____
Signature or Guardian Signature Date

Date:_____

AUTHORIZATION TO RELEASE INFORMATION

I, _____
(Parent Guardian Personal Representative Other)
Authorize **ELIZABETH LADUZINSKI LMHC 7925,** to disclose to and/or obtain mutual release/communication from:

_____ Phone # _____

The following information regarding:

_Assessment
_Psychosocial Evaluation
_Psychological Evaluation
_Psychiatric Evaluation
_Treatment Plan or Summary
_Current Treatment Update
_Medication Management Information
_Presence/Participation in Treatment
_Diagnosis
_Educational Information
_Discharge/Transfer Summary
_Continuing Care Plan
_Progress in Treatment
_Demographic Information
Other _____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.
If other purpose,
Specify:_____
_____

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to ELIZABETH LADUZINSKI LMHC 7925, at 20200 West Dixie Hwy. Suite 605b, Aventura, FL 33180. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this consent expires one year from the date indicated above, or as otherwise indicated:_____

Conditions
I further understand that ELIZABETH LADUZINSKI LMHC 7925, will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances:

E-Mail Communication:

I authorize communication via E-Mail. All E-Mails will be deleted following the communication. Any clinical relevant information will be printed and placed on client's chart. E-Mail is not for crisis issues. No one can guarantee the privacy of communication through E-Mail
I will be given a copy of this authorization for my records.

_____ _____

Signature of Parent, Guardian or Personal Representative **Date**

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.)

Check here if patient/client refuses to sign authorization

_____ _____

Signature of Staff Witness **Date**

CONSENT TO TREATMENT

I do hereby seek and consent to take part in treatment by **ELIZABETH LADUZINSKI LMHC 7925**.

I understand that developing a treatment plan with these therapists and regularly reviewing our work towards meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or any procedures provided by the Elizabeth Laduzinski LMHC 7925 and/or the therapist.

I understand that I may stop treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel, or do not show up, I will not be charged for that appointment. On the second missed appointment, I will be charged $100.00 and for every cancelled or no show appointment thereafter I will be charged full fee.

_____

Initial

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatment I receive.

My signature below shows that I understand and agree with all these statements.

_____ _____

Signature of client or person responsible for client) Date

_____ _____

Print name Relationship to client

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of any protected health information by **ELIZABETH LADUZINSKI LMHC 7925,** and the designated treating employee, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations.

I understand that diagnosis or treatment of me by **ELIZABETH LADUZINSKI LMHC 7925** and the designated treating employee, may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment. payment or healthcare operations of the practice. **ELIZABETH LADUZINSKI LMHC 7925**, is not required to agree to the restrictions that I may request. However, if **ELIZABETH LADUZINSKI LMHC 7925** agrees to a restriction that I request, the restriction is binding on the date below.

I have the right to revoke this consent, in writing, at any time, except to the extent that **ELIZABETH LADUZINSKI LMHC 7925** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and collected or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe this information may identify me.

I understand I have a right to review **ELIZABETH LADUZINSKI LMHC 7925** Notice of Privacy Practices prior to signing this document. The **ELIZABETH LADUZINSKI LMHC 7925** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **ELIZABETH LADUZINSKI LMHC 7925**. The Notice of Privacy Practices for treatment is also provided. This Notice of Privacy Practices also describes my rights and the **ELIZABETH LADUZINSKI LMHC 7925** duties with respect to my protected health information.

ELIZABETH LADUZINSKI LMHC 7925 reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Description of Personal Representative's Authority

NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGEMENT OF NOTICE

Patient/Client Name:
DOB _____
SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of **ELIZABETH LADUZINSKI LMHC 7925, ,** Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Elizabeth Laduzinksi at telephone # 786 554-0198.

_____ _____
Signature of Patient/Client **DATE**

_____ _____
Signature of Parent/Guardian or Personal Representative **DATE**

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

__ Patient/Client Refuses to Acknowledge Receipt
__ Copy kept by therapist

_____ _____
Signature of Staff Member **DATE**

Informed Consent for Teletherapy

This Informed Consent for Teletherapy contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully and let us know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Teletherapy

Teletherapy refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of teletherapy is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, is otherwise unable to continue to meet in person, or, as in this case, sickness or pandemic prevents face-to-face interactions. It is also more convenient and takes less time. Teletherapy, however, requires technical competence on both our parts to be helpful. Although there are benefits of teletherapy, there are some differences between in-person psychotherapy and teletherapy, as well as some risks. For example:

- Risks to confidentiality. Because teletherapy sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On our end we will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact teletherapy. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, we will not engage in teletherapy with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in teletherapy, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our teletherapy work.

- Efficacy. Most research shows that teletherapy is about as effective as in-person psychotherapy generally, there is no specific research that shows teletherapy is just as effective as in-person therapy for the type of therapy you will be receiving. Some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic communication

We reserve the right to choose the electronic platform for services. We will use reasonable caution in choosing the platform, mindful of our obligation of privacy and confidentiality to our clients. You may have to have certain computer or cell phone systems to use teletherapy services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in teletherapy.

Confidentiality

We have a legal and ethical responsibility to make our best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that we cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. We will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for teletherapy sessions and having passwords to protect the device you use for teletherapy). The extent of confidentiality and the exceptions to confidentiality that we outlined in the Informed Consent still apply in teletherapy. Please let us know if you have any questions about exceptions to confidentiality.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

Client's Signature _____ Date _____

Elizabeth Laduzinski PA.
Licensed Mental Health Counselor

20200 West Dixie Highway,
Suite 605B,
Miami, Florida - 33180 -

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

EFFECTIVE: September 2013

This Notice of Privacy Practices applies to the following organizations.

Elizabeth Laduzinski PA
Elizabeth Laduzinski
Licensed Mental Health Counselor