DOLORES GUARINI, Ph.D., LLC

615 Washington Rd., Ste. 502 • Pittsburgh, PA 15228
Telephone: 412-892-9044 • Fax: 412-892-9702

Client Information Form

Name: _____

Address: _____

City: _____State: _____Zip: _____

Email address: _____

Phone: May we identify ourselves when we call? Yes / No (Circle One)

Day: _____Evening: _____ Cell: _____

Date of Birth: _____ SS#: _____

Insurance Information

Primary Insurance Name: _____

Policy Holder Name: _____

Policy/Member ID#: _____Group#: _____

Relationship to Insurance Holder: _____ Date of Birth: _____
(Self, Spouse, Child, Other) (Insurance Holder)

Secondary Insurance Name: _____

Policy Holder Name: _____ Date of Birth: _____

Policy/Member ID#: _____Group#: _____

I give my permission to Dolores Guarini Ph.D., LLC and its authorized associates to submit all therapy sessions to my insurance company and release any medical records to the insurance if necessary. I understand that I may be responsible for any sessions my insurance doesn't cover. 24- notice is required for cancellations with the exception of an emergency situation or a fee may be charged for the missed session.

Signature: _____ Date: _____

FINANCIAL POLICY

Please understand that payment for our services is a necessary part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must complete our Patient Information and Insurance forms before seeing their clinician.

FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH OR CHECK OR CREDIT CARD.

Regarding Insurance Coverage

Many insurance companies require you to contact your health plan prior to your initial visit for preauthorization and to be informed about any benefit limitations regarding any type of therapy or treatment that may not be covered, as well as any payment limitations. This is your responsibility and should be completed prior to being seen initially. Payments for non-covered charges are due at that time of service. You will be charged for any services not covered by your health plan. We are required by your health plan to collect any co-payments or co-insurance at the time of each service.

Please Initial_____

Payment Responsibilities

Adult patients are responsible for full payment of charges at the time of service as specified above. (The adult accompanying a minor and/or the parents (or guardians of the minor) are responsible for full payment at the time of service as specified above. For unaccompanied minors, non-emergency treatment may be denied unless a financial agreement has been made with our office to cover any applicable charges.) Delinquent accounts will be turned over to a collection agency after ninety (90) days. In the event that your check is returned to us, we will charge your account a $25.00 fee for processing in addition to the balance due. If the co-pay is not paid in our office on the date of treatment and needs to be billed, there will be an additional $10.00 surcharge added to your bill each month until the co-pay is paid in full.

Please Initial_____

Reports

Any reports that are not a part of your clinical record and must be individually prepared at your request for outside agencies will require a payment at the rate of $25.00 per 15 minutes time spent with a maximum of $100.00 per report. This does not include such items as letters or records sent to your primary care physician, routine releases of information, medication forms for school or other reports that have their own fee schedule in place. These will be completed at no additional cost to you. (Note: Completion of forms not directly relevant to our clinical care is at the discretion of your clinician.)

Please Initial_____

Missed Appointments

Attendance at scheduled appointments is a critical part of your treatment. We require a 24- hour notice of cancellation. Patients who do not show for an appointment or cancel with less than 24 hours' notice are subject to a $50.00 charge. At the discretion of the treating clinician, you may be charged the full fee for habitual missed appointments, as these time slots cannot be filled.

Please Initial_____

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy:

_____ _____
Signature of Patient or Responsible Party Date

In general, the HIPAA privacy rule gives individuals the right to request a restriction on the uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications and disclosure of PHI be made by alternative means, such as sending correspondence to the individuals' office instead of their home.

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GENERAL CONSENT FOR TREATMENT

Patient Name: _____ Date: _____

I, (or_____), hereby authorize Dolores Guarini, Ph.D., LLC, to provide mental health services, diagnostic and therapeutic procedures, and general mental health treatment as may be clinically indicated under general or special instructions. I recognize that my treatment is under the direction of the licensed professional. I understand that my active participation in treatment is required. I certify that no guarantee or assurances have been made to me as to the results that may be obtained. I hereby certify that I have read and fully understand the above authorization.

_____
Signature of Patient (Must be at least 14 years of age)

If the patient is a minor (14 years of age or younger) or is unable to consent, please complete the following:

I certify that the patient is a minor, _____years of age, or is unable to consent because of

_____ (state of physical or mental incapacitation).

_____
Signature

_____
Relationship

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

IF SENDING INFORMATION, I HEREBY AUTHOIZE:

_____
Dolores Guarini, Ph.D., LLC
615 Washington Rd., Ste. 502
Pittsburgh, PA 15228

TO RELEASE INFORMATION TO:

_____
NAME OF PROVIDER OR FACILITY

_____
ADDRESS

_____
CITY/STATE/ZIP

IF REQUESTING INFORMATION, I HEREBY AUTHORIZE:

_____
NAME OF PROVIDER OR FACILITY

_____
ADDRESS

_____
CITY/STATE/ZIP

TO RELEASE INFORMATION TO:

_____
Dolores Guarini, Ph.D., LLC
615 Washington Rd., Ste. 502
Pittsburgh, PA 15228

To release information from the record of: _____

Whose identifying characteristics are: D.O.B.: _____ Sex: ☐ M ☐ F SSN: __ __ __ - __ __ - __ __ __ __

I understand this information is related to my identity, psychiatric/chemical abuse diagnosis, prognosis, and/or treatment. I also understand the

purpose of this release is for: ____ Continued Care Other _____

SPECIFIC INFORMATION TO BE RELEASED:

☐ Psychiatric Evaluation ☐ Mental Health Assessment ☐ Summary of Treatment ☐ Progress Notes ☐ Medical Records

☐ Lab Results ☐ Psychological Testing ☐ Verbal Consultation ☐ Other _____

I understand the following:

- That my health record(s) will not be released or obtained by Dolores Guarini, Ph.D., LLC, unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information (authorization).
- That the release of my health record(s) will be for the purpose stated on this form, and only those items indicated will be released.
- The information released by Dolores Guarini, Ph.D., LLC, under this authorization may be re-disclosed by the receiving party, and therefore Dolores Guarini, Ph.D., LLC, has no responsibility or liability as a result of any re-disclosures, as such, the released information is no longer protected by the Privacy Rule.
- That this authorization is in effect for a period of 90 days from the date of signature, unless a specific time frame is documented; however, no time frame specified shall go beyond one year from the date of signature.
- That I have the right to revoke this authorization form at any time by sending a written request to the entity where the authorization was provided.
- That my decision to revoke this authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the authorization.
- That my decision to revoke the authorization may result in my insurance company not being able to pay for my medical care and I may be liable for payment of the claim.
- That I am entitled to a copy of this completed authorization form and have the right to inspect material to be released.

_____ _____ _____
Effective Date **Signature of Patient/Parent/Legal Guardian/Authorized Rep.** **End Date**

_____ _____
Witness/Relationship to Witness **Staff Obtaining Consent**

***IF PATIENT IS 14 YEARS OF AGE OR OLDER, HIS/HER SIGNATURE IS REQUIRED IN ADDITION TO A PARENT'S SIGNATURE.**

Refusal to release information: _____ _____
Signature **Date**

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Our Privacy Practices: This is a summary of Dolores Guarini, Ph.D., LLC Notice of Privacy Practices. Dolores Guarini, Ph.D., LLC promises to maintain the confidentiality of your protected Health Information (PHI). PHI is the health information about you that we have in our records. Our comprehensive notice is available for you to read in our office or on our web site at **www.doloresguarini.com**. We urge you to read our notice. If you want a paper copy of the Notice, please request it at check-in.

Federal and State Laws: We are required by federal regulations called the "HIPAA Privacy Regulations" to protect the confidentiality of your protected health information. We are also required to comply with Pennsylvania laws that are more stringent than the "HIPAA Privacy Regulations." If you are receiving mental health services, we will comply with the Pennsylvania Law that provides the greatest protection for your health information.

Authorization to Disclose PHI: Except as described in our Notice, it is our practice to obtain your authorization before we disclose your PHI to another person or entity. You may revoke your authorization at any time.

How We Use Your Protected Health information: Our Notice explains how we may use your PHI for treatment, payment, and health care operations. For example, we may use your PHI to plan and provide your care and treatment; communicate with health care professionals; obtain payment for our services; educate and train our staff; and assess and improve our services. We are also permitted to use and disclose your health information as required by law.

Your Rights: Our Notice explains your rights. For example you have the right to request a restriction on certain uses and disclosures of your PHI; inspect and copy your PHI; request amendments to your PHI; and obtain an accounting or list of disclosures of your PHI.

Acknowledgment: Please sign below to indicate that you have read and/or reviewed a copy of our Notice of Privacy Practices:

_____ _____
Signature of patient/parent/legal guardian Date

_____ _____
Authorized Representative Date

_____ _____
Staff Obtaining Signature Date