Stephanie Jackman, LCSW

Informed Consent for Telemedicine Services

Patient Name:	Date of Birth:	Location of Patient:

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to (your name here) providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical record for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care of treatment. I may revoke my consent orally or in writing at any time by contacting (your name here) at (contact information here). As long as this consent is in force and has not been revoked, (your name here) may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient (or person authorized to sign for the patient)

_____ Date: _____

I have been offered a copy of this consent form (patient initials) _____

Stephanie Jackman, LCSW-R **Today's Date: _____**

UPDATED / NEW PATIENT INFORMATION

PATIENT INFORMATION

Patient Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street Name and #) (City) (Zip code)

Home Phone: (_____)_____ Date of Birth: _____

Marital Status: _____ Sex: □ Male □ Female □ Other

PCP Name: _____ PCP Phone: _____

Emergency Contact: _____Relationship to you: _____Phone:_____

INSURANCE INFORMATION

Who is responsible for co-pays, deductibles, non-covered services and other balances: (please check only one)

□ Patient □ Other

Patient's Relationship to Guarantor/Policy Holder: ☐ Self ☐ Spouse ☐ Child □ Other

Policy Holder's Name (if other than self)_____
(Last) (First) (Middle Initial)

Name of Insurance: _____ Policy ID Number: _____

Phone number on back of card: _____Policy Holder's Date of Birth: _____

If your insurance requires you to have an authorization/referral, have you requested this from your PCP: YES ☐ NO ☐

Do you have a second insurance where claims should be submitted? YES ☐ NO ☐

If yes, what is the name of the insurance: _____Policy ID #:_____

Phone number on back of card: _____Policy holder's name:_____DOB_____

Their relationship to you: □ spouse □ other: _____

In consideration of the provision of services to the above named patient rendered by Stephanie Jackman, LCSW-R I agree to be obligated to pay any remaining balance due not covered by my/patient's insurance carrier(s). I also agree to be obligated to pay any fees for missed appointments and/or canceled appointments with less than 24 hour notice, as these charges are not billable to my insurance carrier. In addition, I authorize Stephanie Jackman, LCSW-R to release to parties responsible for payment of my/patient's mental health services such information as may be necessary for the completion of financial obligation; this includes my billing office. All such transactions will be undertaken under conditions of confidentiality.

_____ _____
(Patient/Guardian Signature) (Date)

NOTICE OF PRIVACY PRACTICES

+The following notice describes how your medical information may be used and made known, and how you can get access to this information. Please review the information carefully.

+You have the right to complain to this practice if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to this practice:

Stephanie Jackman LCSW-R, MS
360 Wellington Avenue
Rochester, NY 14619

All complaints will be investigated. No personal issues will be raised for filing a complaint with this practice. For further information about this Privacy Notice, please call me at 585-358-0512

- Your private healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your private healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or problematic event to a biological product (food or medication).
- Your private healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your private healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your private healthcare information may be released only after recieving written permission from you. You may withdraw your permission to release private healthcare information at any time.
- You may be contacted by this practice to remind you of any appointments, healthcare treatment options or other health services thay may be of interest to you.
- You have the right to limit the use of your private healthcare information. However, this practice may choose to refuse your limitation if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive private communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your private healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- This practice is required by law to protect the privacy of its patients. It will keep private any and all patient healthcare information and will provide patients with a list of duties or practices that protect private healthcare information.
- This practice will abide by the terms of this notice. This practice reserves the right to make changes to this notice and to continue to maintain the privacy of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.

RELEASE OF INFORMATION

Stephanie Jackman LCSW-R, MS
360 Wellington Avenue
Rochester, NY 14619
585-358-0512 (Office)
585-861-6827 (Fax)

Client Name: _____

Birthdate: _____

I understand by signing this form, I am allowing *Stephanie Jackman LCSW-R, MS* to disclose to and/or obtain information concerning the above name client to: (*Name and address of the person or institution)*

_____

Description of Information to be Disclosed:

___ Assessment ☐
___ Diagnosis ☐
___ Psychosocial Evaluation ☐
___ Psychological Evaluation ☐
___ Treatment Plan or Summary ☐
___ Testing Information ☐
___ Education Information ☐
___ Presence/Participation in Treatment ☐
___ Continuing Care Plan ☐
___ Other: _____
___ Billing Information ☐
___ Medication List ☐
___ Progress Treatment ☐
___ Treatment Plan Summary ☐

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 purposes, please specify:

_____

The authorization is voluntary and I may cancel this consent to release information at any time by sending written notice to *Stephanie Jackman, LCSW-R, MS* at the address above. I understand that any release which was made prior to my cancellation in compliance with this authorzation shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized redisclosure and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting *Stephanie Jackman, LCSW-R MS* at the address above.

I further understand that *Stephanie Jackman LCSW-R, MS* may not require this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in a denial of those services.

Federal law prohibits the person or organization to whom disclosue 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 redisclosed by the recipient of the information in the following circumstance:

_____

This agreement will expire 90 days from the date of termination of services, unless perviously revoked or otherwise indicated: (*Specify number of days/months)* _____

_____ _____

Signature of Client, Parent or Personal Representative Date:

_____

Relationship if not the Client

_____ _____

Signature of Staff Witness Date:

Specific Authorization for Release of Information Protected by State and Federal Law

I specifically authorize the release of data and information relating to the following: (Circle appropriate information)

Substance Abuse ☐ Mental Health ☐ HIV Related Information ☐

IN ORDER FOR SPECIFIC INFORMATION TO BE RELEASED, YOU MUST SIGN HERE AND ABOVE:

_____ _____

Signature of Client, Parent or Personal Representative Date:

TREATMENT AGREEMENT

Stephanie Jackman LCSW-R, MS
360 Wellington Avenue
Rochester, NY 14619
585-358-0512 (Office)
585-861-6827 (Fax)

FEES: (Payable at time of session)

Individual 60 minute session $80
(First session is $100)

Couples session $120

**You will be charged $60 for missed sessions or those cancelled without 24 hours notice, except in cases of sudden illness..*

Please sign the following if using your Employee Assistance Program Insurance Benefit:

I authorize the release of any information (which may include notes, treatment summaries and diagnosis) necessary to process Employee Assistance claims, to determine medical necessity of treatment, quality of care, or to request additional sessions.

Signature of Client _____ Second Signature of Client (if applicalble) _____

I authorize payment of benefits to be made to Stephanie Jackman LCSW-R, MS for services provided.

Insured Sign Here _____

CONFIDENTIALITY: What you say in therapy, your records and your attendance are confidential except:

- When you give written permission to release information.
- When your records are subpoenaed for legal reasons.
- When reporting is required or allowed by law. (ex. suspected child abuse or neglect, extreme danger to self, suspected elder abuse or danger to others)
- Other expectations as outlined in my HIPAA Notice of Privacy Practices

IN AN EMERGENCY: Please leave a message on my answering machine at any time, and I will return your call as quickly as possible. In a clinical emergency, go to your local emergency room or dial 911.
ENDINGS: You may end therapy at any time. A final phone call or session is requested for closure.
DISCLAIMER: It is understood that any agreements made are between you and I only. The other therapists in the suite operate independent practices, and are not responsible for your care. I also cannot be responsible for the care provided by professionals or groups that I refer you to.
PRIVACY POLICY: By signing below, you acknowledge receipt of my Notices of Privacy Practice. This Notice provides information about how I may use and disclose your private health information. I encourage you to read it carefully. If you have any questions about the Notice or any of the above, please feel free to ask.

Signature of Client _____ Printed Name _____ Date: _____

Second Signature of Client (if applicalble) _____ Printed Name, second client _____ Date: _____