Rebecca Q. Scott, PhD
Diplomate, American Board of Sleep Medicine
Certification, Behavioral Sleep Medicine
Certification, Holistic Health and Nutrition Counseling

140 West 71st Street, #3C, New York NY 10023 Phone: 917-312-3959 Email: rqs@rebeccaqscott.com

PATIENT INFORMATION

Date: _____

NAME: _____ CELL: _____

EMAIL: _____ HOME: _____

ADDRESS: _____ WORK: _____

CITY: _____ STATE: _____ ZIP _____

SEX: M ☐ F ☐ DATE OF BIRTH_____ S.S.# _____

OCCUPATION _____ CHILDREN _____

PARTNER'S NAME_____ _____

PHYSICIAN: _____ SPECIALTY: _____

ADDRESS: _____ TELEPHONE: _____

CITY: _____ FAX: _____

STATE: _____ ZIP CODE: _____SEND REPORTS ? Y [ ] N [ ]

PHYSICIAN: _____ SPECIALTY: _____

ADDRESS: _____ TELEPHONE: _____

CITY: _____ FAX: _____

STATE: _____ ZIP CODE: _____SEND REPORTS ? Y [ ] N [ ]

INSURANCE INFORMATION--MUST BE COMPLETED

PRIMARY INSURANCE CARRIER: _____ POLICY # _____

SUBSCRIBER'S NAME _____ RELATION TO PATIENT_____

CLAIMS MAILING ADDRESS_____

_____

INSURER'S TELEPHONE_____ I.D.# _____

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OFFICE & FINANCIAL POLICY

Welcome to my practice.

Below is important information about Dr. Scott's professional services and current office policy. When signing this document, it represents an agreement between us. We ask that you read it carefully and understand the following terms and conditions before signing. Our office staff will be available to answer any questions you may have about this policy.

BILLING: Dr. Rebecca Scott is not a participating member of any HMO or managed care network. If you have an HMO or managed care policy, you will only be entitled to reimbursement for services if you have **out-of-network benefits.** Please be aware of any existing deductible or "out of pocket expenses" that may be applied for using out-of-network services, as such expenses are your non-reimbursable responsibility.

FEES/PAYMENT: Payment of all office visits is due at the time service is rendered. We accept cash and checks. We do not submit to insurance carriers for office visits, but you will be given an itemized receipt that you can submit to your carrier for reimbursement. It is recommended that you submit claim forms as soon as possible to your carrier and keep a copy for your records.

CANCELLATIONS & MISSED APPOINTMENTS: If you have to cancel an appointment please be sure to do so at least 48 hours in advance. The full session fee will be charged for cancellations without 48 hours notice or for missed appointments. In consideration of other patients, sessions cannot be extended for late arrivals.

INSURANCE: Your insurance policy is a contract between you and your insurance carrier. Any disputes regarding coverage must be addressed directly to your carrier. We will make every effort to obtain appropriate reimbursement for you; however, you are ultimately responsible for timely payment of services

CONTACTING DR. SCOTT: Dr. Scott is not typically immediately available by telephone; however, if you have a question about your care, you can leave a brief voice mail at 917-312-3959 and she will return your call within 48 hours. For routine office matters, you can call her office manager, Ana Perez, at 646-502-5575, Ext 3. If a situation requires an immediate response, please call 911 or go to the nearest hospital emergency room.

You may also email Dr. Scott. Although we make every effort to maintain your privacy, email should be used primarily for communicating logistical information only given that confidentiality cannot be guaranteed through email.

Please sign below when you have read, fully understand and agree to the above terms and conditions.

_____ _____

Signature of patient Date

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CONFIDENTIALITY AGREEMENT

The U.S. Department of Health and Human Services has issued regulations concerning the handling of patient records, whether communicated electronically, on paper or orally. They require health care providers to **explain to their patients how records are kept and used** , to receive patient consent before any information is released to others, to ensure that health information is not used for non-health purposes except as specified by law, and to give patients access to their records as/when appropriate.

In this office, your paper records are filed individually in a chart with your name. There is also an electronic medical record that is password protected and not on an Internet connected system. The office is locked when the office staff is not present. Some laboratory data or other hospital-based records may be stored electronically in the secure hospital based electronic medical information system.

Our office typically provides health information from your records to the following parties:

(1) Consultants who are going to see you.
(2) Physicians and health professionals who have referred you to us or are involved in your care.
(3) Your health insurer when needed to document service or a diagnosis.

For these 3 specific purposes we are requesting your written approval below (which you are free to revoke by written notice at any time). If you do not wish to share information with your insurer, you agree to pay for the service in full personally.

For any other purpose, no records will be shared with any outside agency except by your specific written approval. The most common would be from a life or disability insurance carrier who will send a copy of your signed permission with their request.

I have read and understand the materials above. I have had the opportunity to ask any questions I. might have and to have them answered to my satisfaction. I hereby voluntarily give my approval to release any necessary portions of my records or any report concerning them as explained above.

I understand any other release of my records in an identifiable manner will require an additional specific approval on my part.

Signed: _____

Print Name: _____

Date: _____

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LIMITS OF CONFIDENTIALITY

The contents of a behavioral medicine intake, assessment or session are considered to be confidential. Both verbal and written records about a client cannot be shared with another party without the written consent of the patient of the patient's legal guardian. It is the policy of this practice not to release any information about a patient without a signed release of information. However, there are limits to confidentiality and these are exceptions are indicated below.

Duty to Warn and Protect: When a patient discloses intentions or a plan to harm another person, the health care professional is required by law to warn the intended victim and report this information to legal authorities. In cases in which the patient discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempt to notify the family of the patient.

Abuse/Neglect of Children and Vulnerable Adults: If a client states or suggests that he or she is abusing and/or neglecting a child or vulnerable adult or had recently abused or neglected a child or vulnerable adult, or a child/vulnerable adult is in danger of abuse or neglect, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances: Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Patient's Death: In the event of a patient's death, the spouse or parents of a deceased patient have a right to access their child's or spouse's records.

Professional Misconduct: Professional misconduct by a health care professional must be reported by other health care professions. In cases in which a professional or legal disciplinary meeting is being held regarding the health professional's actions, related records may be released in order to substantiate disciplinary concerns.

Court Orders: Health care professionals are required to release records of patients when a court order has been placed.

Minors/Guardianships: Parents or legal guardians of non-emancipated minor clients have the right to access the patient's records.

Other Provisions: When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, case notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, time frame, and the name of the clinic. Insurance companies and other third party payers are given information that they request regarding services to patients. Information which may be requested includes type of services, dates/times of service, diagnosis, treatment plan, description of impairment, progress of treatment, case notes, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases, the mane of the patient, or any identifying information, is not disclosed. Clinical information about the patient is discussed.
I agree to the above limits of confidentiality and understand their meanings and ramifications.

Patient's name (please print)_____

Patient's (or guardian's) Signature_____ Date:_____

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HIPPA Notice of Privacy Practice

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health services.

1. Uses and Disclosures of Protected Health Information
Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice. And any other use required by law.
Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information may be used, as needed, to obtain payment for your health care services. For example, obtaining approval for hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
Heathcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: Required by law, Public Health issues as required by law, Communicable Diseases: Health Oversight, Abuse or Neglect, Food and Drug Administration requirements; Legal Proceedings: Law Enforcement _____, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation, Inmates, Required Uses and Disclosures, Under the law, we must make disclosures to you and required by the Secretary Department of Health and Human services to investigate or determinate our compliance with the requirements of Section 164.500.
Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.
You may revoke this authorization, at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.
You have the right to inspect and copy tour protected health information.
Under federal law, however, you may not inspect or copy following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your doctor is not required to agree to a restriction that you may request. If your doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected heath information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternatives means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complains: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.
This notice was published and becomes effective on/or before April 14, 2003
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with us in person or by phone at our Main Phone Number.

Signature below is to acknowledge that you have received this Notice of our Privacy Practice:

PATIENT NAME:_____

PATIENT'S SIGNATURE:_____

DATE _____ / _____ / _____

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Authorization For Release Of Information

I give Rebecca Q. Scott, PhD permission to contact and get history and information from the following people /institutions:

Name:	Telephone:
_____	_____
_____	_____
_____	_____
_____	_____

I hereby authorize Dr. Rebecca Scott to:

___ Release information to:
___ Obtain information from:
___ Exchange information with:

Name:_____ Name:_____

Address: _____ Address: _____

Phone: _____ Phone: _____

The information requested or authorized for release or exchange pertains to:

___ Mental Health
___ Education
___ HIV / AIDS
___ Sexually transmitted diseases
___ Drug or alcohol abuse

This authorization is valid for 90 days from the date below or _____, (not to exceed 1 year). I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

Signature: _____ Date: _____

Printed Name: _____ DOB:_____

Relationship to Patient: _____ (self, parent, legal guardian)