PATIENT INFORMATION/HIPAA FORM

DR ALEX MARSAL | LISCENSED CLINICAL PSYCHOLOGIST | TROY, NY

PERSONAL INFORMATION

Patient Name: _____

Marital Status: _____

Street Address: _____

_____

State: _____

City: _____

Zip Code: _____

Home Phone: _____

Work Phone: _____

Date of Birth: _____

Social Security Number: _____

Mobile Phone: _____

Email: _____

EMPLOYER INFORMATION

☐ Employed ☐ Unemployed ☐ Retired

Employer's Name: _____

Address: _____

_____

City: _____

State: _____

Zip Code: _____

PRIMARY INSURANCE INFORMATION

☐ Insured ☐ Uninsured

Primary Insurance: _____

ID Number: _____

Group Number: _____

Name of Subscriber: _____

Subscriber Date of Birth: _____

Subscriber Mailing Address: _____

_____

City: _____

State: _____

Zip Code: _____

Employer of Subscriber: _____

Employer Address: _____

City: _____

State: _____

Zip Code: _____

Relation to Patient: _____

SECONDARY INSURANCE INFORMATION

☐ No Secondary Insurance

Secondary Insurance: _____

ID Number: _____

Group Number: _____

Name of Subscriber: _____

Subscriber Date of Birth: _____

Subscriber Mailing Address: _____

_____

City: _____

State: _____

Zip Code: _____

Employer of Subscriber: _____

Employer Address: _____

City: _____

State: _____

Zip Code: _____

Relation to Patient: _____

REFERRAL / MEDICAL INFORMATION

Refereed By: _____

Name of Primary Physician: _____

Physician Phone: _____

Physician Address: _____

Current Medical Problems: _____

_____

_____

Current Medication & Dosages: _____

_____

_____

HIPAA NOTICE OF PRIVACY

This Privacy Notice explains your rights regarding your health care records. You will be given a copy of this Privacy Notice to keep for your records. A new government rule requires that this Privacy Notice be given to you to sign.

As a private practitioner of psychotherapy services, I am committed to guarding your treatment records and personal information. Personal information gathered by this provider is kept both in written form and on computer. All written material is stored in locked file cabinets. All information on a computer is password protected. These records include the information gathered at the time of the initial assessment and information relating to the ongoing treatment sessions and progress.

Personal and treatment information is not shared with any other professionals without your permission and signature. Your medical record is never shared with anyone in its entirety unless I am subpoenaed or at your request. Please

remember that even if you sign a release form for some other professional, I'll be happy to send a summarized letter, but will never send complete copies of your medical record.

For the purpose of billing, personal and treatment information needs to be shared with the insurance or managed care company. This consent form gives permission to share information with my office manager and with your insurance company for the duration of your treatment or until you revoke this consent for disclosure.

Any other release of information will only be done after written authorization is obtained from you or your legal guardian. Each authorization will explain what information is being disclosed, to whom, and for what purpose.

After treatment is complete, you consent to allow Dr. Marsal's office to contact you in six months for a follow-up evaluation. You have the right to view your medical records and to be informed about any disclosures made after authorization is given. Any questions about your health record should be directed to Dr. Marsal. You have the right to receive additional copies of this notice if needed.

I Agree to the above HIPAA Notice of Privacy

Initials: _____

INFORMED CONSENT

I authorize the release of any medical or other information necessary to process any claims. I hereby authorize payment directly to Dr. Alex G. Marsal of the benefits payable. I understand that I am financially responsible for any charges not covered by my insurance.

I understand that I am solely responsible for the payment of any session that I miss or cancel within 24 hours of the scheduled appointment. I understand that I will be charged $50.00 for an appointment missed or not canceled. If balance exceeds $100, Dr. Marsal will work out a payment plan with me and schedule an appointment after my account has been satisfied.

I Agree to the above Informed Consent:

Initials: _____

PATIENT NAME (Please Print Name): _____

SIGNATURE: _____

DATE: _____

Please note: When the form is completed please save the document with your information before sending. Send your filled-out form to info@dralexmarsal.com or print the form out and bring it with you to your appointment. We are not responsible for the secured transmission of your personal information through email, online transmission, faxed, mailed, or any other form of delivery that you choose.