Marcia E. Brubeck, LLC
Client Registration Form

Intake Date_____ DSM code(s) _____

Client Information

Client Name_____ Date of Birth_____
Address_____ Social Security #_____
_____ Relationship to Insured (which?):
_____ self spouse child other
_city state zip Status: S___ M___ D___ Sep___ Wid___
Phone _____ (cell?) Y/N ___ Work_____
Email address_____ Referred by_____
Primary Physician_____ PCP Town_____
Emergency Contact_____ Phone_____

Insured/Guarantor Information

Insured's Name_____ Date of Birth_____
Address_____ Driver's License #_____
_____ Gender: M____ F____ Other____
_____ Employment Status (which?):
city state zip full time part time unemployed retired
Phone _____ (cell? land?) Phone (w)_____
Employer_____ Occupation_____
Insurance Company*_____ Plan Type_____
Insurance ID#_____ Group #_____
Insurance Phone_____ Insurance copay_____

*If other insurance covers this client, please print the name, identification and group numbers, and telephone on the back of this form.

Beneficiary/Guarantor Attestation

- I request that payment of the authorized insurance, or Medicaid, benefits be made on my behalf to Marcia Brubeck for services she furnishes to me or my dependents. I authorize any holder of medical information about me or my dependents to release to the Health Care Financing Administration and its agents or to my insurance company any information needed to determine the benefits payable for related services.
- I understand that even though Marcia Brubeck or her agent will submit claims to my insurance, I am responsible for the portion of my bill considered to be my insurance copayment, coinsurance, deductible, or other charges not covered by insurance, including nonpayment for my failure to comply with insurance guidelines regarding prior authorization of treatment. I also understand that a collection agency may be invoked for failure to pay.
- I understand that there will be a charge for late cancellation (less than 24 hours) or failure to appear for an appointment., which are not covered by insurance. If I am covered by Medicaid, I understand that I will be discharged after two no-shows or late cancellations, since under Medicaid, by law, no such fees may be charged to the client.

_____ Date_____
Signature of Beneficiary/Guarantor

MARCIA E. BRUBECK, LLC
INITIAL SESSION

Patient:_____ Date of Birth:_____

Address: _____

City:_____ State: _____ Zip: _____

Cell Telephone: _____ Home Telephone: _____

Gender Identity (M/F/Other):_____ Pronouns:_____

Employer/School: _____ Occupation: _____

Marital Status: ____ Married ____ Single ____ Divorced ____ Widowed ____ Separated

Emergency Contact:_____ Telephone:_____

Relevant medical conditions: _____

_____

_____

_____

Medications:_____

_____

_____

_____

Prescribing Physician:_____

Allergies/adverse reactions to treatment: _____

_____

Primary Care Physician Name: _____

Address:_____ City_____ Zip_____

Telephone: _____

Have you had psychotherapy before? ___Yes ____No

Reason for seeking counseling today: _____

_____

_____

_____

Client Signature_____ Date _____

Marcia E. Brubeck, LLC

Marcia E. Brubeck, JD, LCSW, Member

CONSENT TO TREATMENT AND RULES OF THE HOUSE

I hereby give Marcia E. Brubeck, LCSW, permission to provide me with outpatient psychotherapy in accordance with a plan that she will discuss with me and that may include individual, family, and group therapy provided in the office, in the community, and/or in my home or via telemedicine.

As a client (or the parent of a client), I have the right to be treated with respect and honesty. I expect my treatment to reflect the highest professional and ethical standards. I am free to terminate the therapeutic relationship without fault whenever I choose.

Outpatient psychotherapy does not carry significant risks. Regular attendance is necessary for maximum benefits. I understand that treatment is expected to be beneficial but that there are no guarantees and that during treatment an individual may feel temporarily worse.

During the term of our treatment, you may contact me by telephone or email. I respond to telephone calls and emails as promptly as I can, generally within 24 hours during the work week (Monday-Thursday). I may take notes on our phone conversations. Please bear in mind that I cannot ensure the confidentiality of voice or text messages. I recommend that you email me using secure email software such as Sendinc. Your emails may become part of my clinical record. I am happy to provide you with a copy of the clinical record any time you wish to see it.

I maintain an Internet presence in the form of a website, several Facebook pages, and profiles on other media sites. These sites include professional information about me and items of possible interest to clients and consumers of my information products and services. You are free to "friend" me or sign up to receive information through these sites. I do not use the Internet to research clients unless the Internet figures in the client's treatment goals.

Please note:

1. Appointments start on the hour. If you arrive early for your session, please wait in your car.
2. Unless you alert me that you will be late for your session, I will not wait more than 20 minutes.
3. You are responsible for verifying your insurance coverage and determining the appropriate copayments and deductibles. You are also responsible for verifying that your insurance company recognizes me as an in-network or out-of-network provider. If you have a deductible, I ask you to pay the negotiated session fee at the time of service. Once your insureer has issued an EOB, I will refund the amount of your insurer's reimbursement. This policy nsures that your account remains current with no large balances due.
4. Payments are due at the **start** of each session.
5. If you fail to appear for a scheduled session or if you cancel less than 24 hours beforehand, you will be charged the amount that your insurance would have paid me, payable before additional services are rendered, unless the terms of my contract with your insurance company specify that I may not charge you for late cancellations or no-shows..

A copy of this authorization will be considered valid.

_____

Name of Client(s) Receiving Treatment

_____

Signature of Individual Age 14 or Older Date

_____

Signature of Parent or Guardian (if applicable) Date

Marcia E. Brubeck, LLC
114 Somerset Street, West Hartford, CT 06110 • (860) 231-1997 (T) • (860) 231-1960 (F)
www. MarciaBrubeck.com • MBrubeck1@gmail.com

Informed Consent to Telemedicine

I, _____, hereby consent to participate in mental health services provided via telemedicine as part of my outpatient psychotherapy. I understand that telemedicine is the practice of delivering clinical health care via technology-assisted media or other electronic means and that the practitioner and the client are in two different locations.

I understand that I have the right to withdraw my consent at any time without my withdrawal's affecting my right to receive future care, services, or benefits to which I would otherwise be entitled.

1. I understand that telemedicine is associated with risks and consequences including, but not limited to, the disruption of transmission by technology failures, interruptions and/or breaches of confidentiality by unauthorized persons, and/or limitations on Marcia E. Brubeck's ability to respond in emergencies. Marcia E. Brubeck, LLC, makes no guarantees or assurances about the results of this service.

I will not record any of the online sessions, and I understand that Marcia E. Brubeck will not do so either. All information disclosed within sessions, and written records pertaining to those sessions, will remain confidential and may not be disclosed to anyone without written authorization except where disclosure is permitted and/or required by law.

I understand that the privacy laws that protect the confidentiality of my protected health information (PHYI) also apply to telemedicine unless an exception to confidentiality applies, such as the governor's executive orders in a public health emergency; the mandatory reporting of abuse to a child, elder, or vulnerable adult; a danger that I present to myself or others; or, in a legal proceeding, when I raise mental or emotional health as a legal issue.

I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, Marcia E. Brubeck may determine that telemedicine is not appropriate and that I require a higher level of care.

I understand that if technical difficulties cause service interruptions during a session, we may need to end and restart the session. If we are unable to reconnect within ten minutes, please call Marcia E. Brubeck at (860) 231-1997 to discuss rescheduling.

I agree to inform Marcia E. Brubeck of my physical address at the start of each session. I understand that, in case of emergency, Marcia E. Brubeck may need to call my identified emergency contact and may also need to contact appropriate authorities.

I agree to permit my healthcare information to be shared with other individuals for the purpose of billing. If my insurance does not cover telemedicine services, I understand that I must pay the full fee directly to Marcia E. Brubeck, LLC.

I have read the information provided above and have discussed it with Marcia E. Brubeck. I understand the information contained in this form, and all of my questions have been answered to my satisfaction.

_____
Name of client/parent/legal guardian

_____ _____
Signature of client/parent/legal guardian Date

_____ _____
Marcia E. Brubeck, JD, LCSW Date

Important Note

If you decide to opt out of using insurance, please initial below. You may pay for your session by Paypal either by going to the Paypal button on the Telemedicine page of ***www.MarciaBrubeck.com*** *or by going to* ***Paypal.me\MarciaBrubeck****.*

_____ I request that Marcia E. Brubeck, LLC, not bill my insurance for telemedicine sessions,

and I agree to pay $_____ per session of telemedicine for the duration of my telemedicine treatment.

Marcia E. Brubeck, LLC
In West Hartford: 114 Somerset Street, West Hartford, CT 06110 • (860) 231-1997/ phone • (860) 231-1960 / fax

Primary Care Physician Collaboration Form

Client_____ Insurance _____ DOB_____
PCP Name_____ PCP Phone _____

Client ID#_____ Group #_____ Date of first visit_____

Presenting problem_____

_____

Current psychotropic medications_____

Prescribing psychiatrist_____

Client is currently receiving (check all that apply): □ individual psychotherapy □ family therapy □ couples counseling

□ group therapy □ medication monitoring □ case management □ other:_____

Please contact me if additional information would be helpful.

I hereby authorize Marcia Brubeck, LCSW, to release a copy of this form to my primary care provider, _____

_____, and speak by telephone to this provider for the purpose of coordinating care and ensuring continuity. This consent will remain valid for the course of my psychotherapeutic treatment. I understand that I may revoke this authorization at any time by giving Marcia Brubeck written notification of revocation.

_____ _____
Patient age 14 or older Date

_____ _____
Parent or guardian (if applicable) Date

_____ _____
Marcia E. Brubeck, LCSW Date

□ Patient to deliver □ Mailed □ Faxed

I prefer that my primary care physician not be contacted regarding my treatment.

_____ _____
Patient age 14 or older (or parent or guardian) Date

_____ _____
Marcia E. Brubeck, LCSW Date

Marcia E. Brubeck, LLC • Marcia E. Brubeck, JD, LCSW, Member
114 Somerset Street, West Hartford, CT 06110
(860) 231-1997 T (860) 231-1960 F

Notice of Privacy Practices

Patient/Client Name:_____

I hereby acknowledge that I have received a copy of Marcia E. Brubeck's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Marcia E. Brubeck, JD, LCSW.

I authorize Marcia E. Brubeck, LLC, to notify me by telephone or verbally in the event of a breach of my protected health information (PHI) by Marcia E. Brubeck, LLC. Any such conversation shall be documented by Marcia E. Brubeck, LLC.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Marcia E. Brubeck, LLC.

_____

Signature of Patient/Client ***Date***

_____

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

**If you are signing as a personal representative of an individual, please indicate the nature of your legal authority*

_____

Signature of Staff Member *Date*

Marcia E. Brubeck, LLC
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Marcia E. Brubeck, LLC.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Marcia E. Brubeck, at 114 Somerset Street, West Hartford, CT 06110 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013.