JAMES LEVINE & ASSOCIATES
Your Partner in Behavioral Health Solutions

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of James Levine & Associates. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information or PHI. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you will be provided a copy and a revised copy will be posted in our offices.

If you have any questions about our Notice of Privacy Practices, please contact our Privacy Officer Mara Veronesi LICSW at (413) 534-7400 ext. 115.

I acknowledge receipt of the Notice of Privacy Practices of James Levine & Associates.

Name of Client or Guarantor (printed) _____

Signature of Client or Guarantor _____ Date _____

Guarantor's Relationship to Client _____

For Office Use Only

Client Refuses to Acknowledge Receipt of Notice of Privacy Practices

Signature of Staff Member _____ Date _____

9 College Street, Suite 6
South Hadley, Ma. 01075

(413) 534-7400
(413) 534-7483 (FAX)

CLIENT INFORMATION

Client Name: _____ Date of Birth: _____

Social Security No: _____ Address: _____

City: _____ State: _____

Zip: _____ Home #: _____

Cell #: _____ Work #: _____

If you're choosing to use Insurance, Please Complete

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Insurance Company: _____ I.D. # _____

Subscriber's Address: _____ State: _____

Zip: _____ Employer's Name: _____

Home #: _____ Cell #: _____

Work #: _____

If you are choosing to self-pay, Please Complete

Financially Responsible: _____ Address: _____

Relationship to Client: _____

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SERVICE AGREEMENT AND FINANCIAL POLICY

Thank you for choosing James Levine & Associates as your behavioral health care provider. It is our goal to provide you with the best care possible, as well as exceed your expectations regarding the handling of your account. As such it is important that you understand the policies of our office. We are happy to answer any questions you may have regarding these policies.

Insurance: We will be glad to bill your insurance company. We will verify your insurance benefits to the best of our ability. Please understand that this does not guarantee payment. You (the client) are ultimately financially responsible for knowing and understanding your policy and benefits. We will discuss any issues we come across with your insurance policy and we will work on your behalf to resolve the issue in a timely manner. If you do not have insurance, all payments are due at the time services are rendered.

Disclaimer: BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS SUCH AS DEDUCTIBLES MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.

If my insurance determines that a medical service and/or material is not covered, I acknowledge that I have been notified and assume full financial responsibility for the services and/or materials rendered.

Subpoena's and Court Involvement: Please be aware that in the event a clinician is subpoenaed, or requested by a client to participate in any legal proceeding, since insurance companies will not reimburse for this service, the client will be responsible to pay our standard rate of $90 per hour for this service. These services include but are not limited to Guardian ad litem, report writing, time spent in court, travel time, phone contact with court personnel or any other time deemed necessary to fulfill the requirements associated with the legal proceedings.

(Please initial) _____

Co-Payment / Co-Insurance/ Deductibles: Your co-pay is due at the time of each visit. If you do not have your co-pay, you may be charged a late fee of $5.00.

(Please initial) _____

No-Show / Late Cancellations: Please take note there may be a $75.00 no show fee for all appointments which are not cancelled with at least 24 hour notice. This is routine policy in psychotherapy practice due in part to clinician compensation which is determined by services provided and a timely cancellation allows the therapist to reschedule the hour. Any late cancellation or no show will be billed directly to you, as insurance cannot be billed.

(Please initial) _____

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Confidentiality: All communication in therapy is considered privileged information and held confidential according to Massachusetts state laws for Mental Health Providers and as required by the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our office will post a copy of our current Notice of Privacy Policy in a visible location at all times, and you may request a copy of our most current Notice at any time.

Types of Payments: We accept cash or check at this time. Any returned checks will be subject to a $25.00 insufficient fund fee in addition to the amount of the check. If an account has more than two (2) returned checks, James Levine and Associates will no longer accept personal checks as payment and the Client must make payments with cash, money order or certified bank checks.

I certify that I have read and understand the information listed above. I understand that it is my responsibility to ask questions regarding these policies.

Client Name (printed): _____

Client / Guarantor Signature: _____ Date: _____

As a reminder, it is our policy to update all paperwork each year.

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INSURANCE AUTHORIZATION

I hereby authorize James Levine & Associates, P.C. to release pertinent Public Health Information for purposes of billing and authorization of psychotherapy services to:

Insurance Company: _____

An authorized signature is mandatory when you inform us that you are insured and want James Levine & Associates, P.C. to make claims on your behalf.

I _____ authorize James Levine & Associates, P.C. to bill my Insurance Company
(Client or Guarantor)
for all services rendered on my behalf or on the behalf of my dependant.

I further attest by my signature that I am legally authorized either by relationship or court order to consent for these services.

Signature: _____ Date: _____

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James Levine & Associates supports an Integrated Care Model facilitating collaboration between therapists and our clients' Primary Care Physicians. Such collaboration allows us to more fully address the spectrum of issues confronted by our clients and to coordinate treatment options and implementation. Your participation is completely voluntary.

Physician's Name: _____ Telephone: _____

Address: _____
Client Name: _____ (Date of Birth: _____) has requested that we coordinate services to better assist them with the following issue which has brought them in for psychotherapy services;

I look forward to speaking with you,

Sincerely, _____

AUTHORIZATION TO DISCLOSE INFORMATION

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law which prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations

This consent shall expire one (1) year from the date of signature. I understand I may revoke my consent in writing at any time except to the extent that action has already been taken in reliance on it. Client, please check one:

☐ I agree to release this information to my physician listed above.

☐ I do not agree to release this information to my physician listed above. (Reason)

Patient's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

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