Marissa Patsey LLC
Marissa Patsey, MEd, LPC
Psychotherapist & LGBTQIAA+ Consultant

Heights Center Building, Suite 7
12429 Cedar Road
Cleveland Heights OH 44106
440-941-7670

Date _______________

Name:____
Pronouns:_____________________________________

Home/Cell Phone ______________________________________
Work phone ____
Email Address ____

Address ____
City ____
State ____
Zip ____

Date of Birth__________Age___ Gender_________Sexual Orientation_________

Name of person who referred you to me: ____________________________

Contacting You – Information

In an effort to protect your privacy, when contacting you I will identify myself by my name only and not by my position as a psychotherapist. That stated:

May I contact you at work if necessary? (Circle One) Y N

May I leave a message on your voicemail? At home? (Circle One) Y N
At work? Y N
On your cell? Y N

May I email you? Y N

Please comment on any restrictions to the above____

Emergency Information

In case of emergency, contact:

Name ____

Relationship to client____

Telephone: (Home)________________________(Work)____________________________

(Cell)_________________________________

Address (Street, City, State, Zip): _____________________________________

Medical Information

Physician name: _____________________________________

Physician phone number: ____________________

Psychiatrist name (if applicable): ___________________________________

Phone_______________________________________

Current Medications: ____

Intake Information

Reason you are coming to therapy:

____
____
____
____
____
____
____
____
____

Have you been in therapy before? How did it go?

____
____
____
____
____

Please give a brief account of your current living situation (who you live with, etc, and any information you think is relevant)

____
____
____
____
____

Please tell me anything else you think is important for me to know about your situation before we meet.

____
____
____
____
____
____

Payment

Please Read Carefully! My office handles payment differently than many health care providers.

<u>I ask my clients to pay for services directly at the time of service</u>. I do not accept direct assignment from insurance carriers. For your convenience, I accept credit, debit cards (Master Card, Visa, and Discover), cash or check. If my rates are outside of your budget, please feel free to inquire if I am able to offer you a sliding scale rate.

Marissa Patsey LLC
Professional Services Agreement

Ohio State Counselor, Social Worker and Marriage & Family Therapist Board regulations require that all clients are fully informed regarding the costs of professional services. Following is a list of fees and a summary of my billing practices. I ask that you read this material carefully, and sign below to signify your acceptance of these terms.

FEES:

Office visit (Individual, 60 minutes):	$140
Office visit (Individual 75 minutes):	$155
Office visit (Individual 90 minutes):	$190
Office visit (Couples, 60 minutes):	$160
Office visit (Couples 75 minutes):	$185
Office visit (Individual 90 minutes):	$200
Telephone Consultation	Office visit rate, pro rata
E Mail Consultation	Office visit rate, pro rata

Skype or Face time Consultation	Office visit rate, pro rata

Payment is expected in full at the time of the office visit.

CANCELLATION:
Twenty four (24) hour notification is requested for all cancellations of appointment time reserved. Same-day cancellations for emergencies may be discussed with provider.

MISSED APPOINTMENTS:
Upon a first missed appointment, clients will not be charged a fee. However, for each subsequent missed appointment clients will be charged full session fee.
Account balances over 60 days due may be submitted to my attorney for collection.

I have read and understand the above, and accept full financial responsibility for fees incurred within the framework of this agreement.
I have received and read the Privacy and Confidentiality Notice Form.

____________________________________ ______________________________

Your name (Please print) Your Signature and Today's date

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Consent to use credit/debit for session(s)

I_________________________________

Give my consent to Marissa Patsey LPC to use (please check one)

MC____ VISA____ DISCOVER____AMEX____HSA_____

For session (s).

Name on Card___________________________

Card Number____________________________

Expiration Date__________________________

CV #__________________________________

Billing Address___________________________

____

____

Signature_______________________________

Today's Date_____________________________

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Consent for Release of Information

I_________________________________

Give my consent to Marissa Patsey LPC to obtain/release treatment information to/from the following:

Name ______________________________________

Address_____________________________________

Phone______________________________________

Email__________________________________

for the purpose(s) of:

___Coordination of Care

I understand that authorization shall remain valid from the date of my signature below and ending one year from that date or at termination of services.

I have been informed that I may revoke this authorization by written or oral communication with Marissa Patsey LPC at any time.

I certify that this form has been fully explained to me and that I understand its contents.

______________________ __________________
Signature of Client Date of Authorization

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State of Ohio Notice Form (HIPAA)

I. NOTICE OF PSYCHOTHERAPIST'S POLICIES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law, part of which became effective on April 14, 2003. It requires, among other things, that the privacy of health information, be safeguarded in very specific ways with regard to its use, disclosure and transmission. This individually identifiable information is referred to as Protected Health Information (PHI).

HIPAA also delineates various rights you as the client have regarding access to and control of your PHI. State laws and professional Codes of Ethics may supercede the HIPAA requirements in those cases where state laws or ethical codes may be more protective, or where your rights may be more expansive.

As a clinician, I am required by law, along with other health care providers to maintain the privacy of your PHI and to provide you with notice of my legal duties and Privacy Practices. I must abide by the terms of this notice and may reserve the right to change the terms of this Notice of Privacy Practices at any time as changes in federal and state laws require. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. Any new Notice of Privacy Practices will be effective for all PHI that is maintained at that time. In such case, you will be provided with a copy of the revised Notices at your next scheduled appointment, or at your request, a copy may be sent via US mail.

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

PLEASE REVIEW THIS CAREFULLY.

II. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I (psychotherapist at MARISSA PATSEY LLC) may use of disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. Your consent of authorization is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposed outside of treatment payment and health care operations. I will obtain an authorizations from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes are notes that I have made about our conversation during a private, group, joint, or familycounseling session, and that I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on an authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

I may use or disclose PHI without your consent or authorization in the following circumstances:

~Child Abuse:

If, in my professional capacity, I know or suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, I am required by law to immediately report that knowledge or suspicion to the Ohio Public Children's Services Agency, or a municipal or county peace officer.

~Adult and Domestic Abuse:

If I have reasonable cause to believe that an adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, I am required by law to immediately report such belief to the county department of Job and Family Services.

~Judicial or Administrative Proceedings:

If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release this information without written authorization from you or your persona legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. you will be informed in advance if this is the case.

~Serious Threat to Health or Safety:

If I believe you pose a clear and substantial risk of imminent serious harm to yourself or another person, I may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to me an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and I believe you have the intent and ability to carry out the threat, then I am required by law to take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian of a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).

~Worker's Compensation

If you file a worker's compensation claim, I may be required to give your mental health information to relevant parties and officials.

IV. PATIENTS RIGHTS AND PSYCHOTHERPIST'S DUTIES

Patients Rights:

~Right to Request Retsrictions~

You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction upon your request.

~Right to Receive Confidential Communications by Alternative Means and at Alternative Locations

You have the right to request and receive confidential communications of PHI by alternative means at alternative locations. For example, you may not want a family member to know that you are seeing me. (Upon your request, I will send your bills to another address).

~Right to Inspect and Copy

You have the right to inspect or obtain and copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions for you as long as the Bill is maintained in the record. I may deny access

to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request process.

~Right to Amend
You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request I will discuss with you the details of the amendment process.

~Right to Accounting
You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your request, I will discuss with you the details of the accounting process.

~Right to a Paper Copy
You have the right to obtain a paper copy of the notice from me upon my request, even if you have agreed to receive the notice electronically.

PSYCHOTHERAPIST'S DUTIES:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will notify you by mail.

V. COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree, with a decision I made about access to your records, you may contact me at (440) 941-7670. You may also contact my supervisors Roberta Taliaferro, LPCC-S or Jacqueline Salter, LPCC-S.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services (233 N Michigan Ave Ste 240 Chicago IL 60601). There will be no retaliation against you for filing a complaint.

VI. EFFECTIVE DATE, RESTRICTIONS AND CHANGES TO PRIVACY POLICIES

This notice will go into effect March 31 2006.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by posting a copy in my office. A copy of the posting will be available onrequest.

ACKNOWLEDGEMENT OF RECEIPT OF MARISSA PATSEY LLC NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of MARISSA PATSEY LLC Notice of Privacy Practices.

Client Name (Print) and Signature____

Date________________