Different Like Me, Inc.

IMPORTANT INFORMATION AND CONSENT FOR TREATMENT

Thank you for choosing this service. This sheet describes some details about our professional relationship. If there is anything you do not understand please ask me and I will be happy to discuss it with you.

Appointments and Fees

Fees for service are payable at the time of each visit, unless other payment arrangements have been established. You are responsible for the annual deductible and any percentage of the fee not covered by your insurance plan. We will gladly fill out any insurance claim forms for you so that *you* can be reimbursed. Your appointment time is reserved just for you. You are responsible for the full fee for all scheduled appointments, and ***will be charged for any canceled appointment unless you notify us at least 24 hours in advance***. There is a $30.00 bank charge fee for any returned check.

Confidentiality

We are committed to protect your privacy and confidentiality to the fullest extent possible in accordance with the Federal Health Insurance Portability and Accountability Act (**HIPAA**) and Florida Laws 491.0147 and 394.459 and Title 42 of the Code of Federal Regulations (chemical abuse/drug addiction).
You will have an opportunity to receive the Notice of Privacy Practices under **HIPAA.**

Communication with clients and clients' communication with his/her therapist is considered privileged communication under the law. No disclosure of information about a client, current or past, may be released to any person or agency without a written consent for release of information properly executed and signed by the client. This rule applies equally to both written and oral communications.

The current state laws and regulations limit confidentiality and require disclosure under the following circumstances: (1) A receipt of a valid court order. (2) If there is any suspicion of physical, sexual, or emotional abuse and/or neglect of a child, we are required by law to inform the Florida Department for Families and Children. We are also required by law to inform Adult Protective Services, Department of Elder Affairs, if there is any suspicion of physical abuse of a dependent adult. (3) If we have a reasonable cause to believe that you are a danger to yourself or to the person or property of someone else, then disclosure must be made to an appropriate individual or agency that can prevent the threatened danger. The written case record is kept for seven years and is then destroyed by shredding.

Insurance Assignment and Consent for Treatment

By signing below you are authorizing the release of any necessary information about your case to your primary and, if applicable, secondary insurance or Medigap company to process your insurance claim. You are also assigning benefits to Different Like Me, Inc. for any eligible payments from any insurance carrier, including Medicare and Medigap. This is a direct assignment of the rights and benefits under the insurance policy. You agree to pay any balance due over insurance payments. You understand that you do not need to provide your supplemental insurer with information concerning your Medicare claim, because signing this authorization will cause Medicare payment to cross over automatically. A copy of this assignment shall be considered as effective and valid as the original.

I have read and understand the above, and agree to engage your professional services under these terms and conditions.

(Print Name)_____ ***DOB:***_____

(Signature)_____ ***Date:*** ____/____/____

Different Like Me, Inc.
Authorization For Disclosure

I, _____ [Insert Name of Patient/Client], whose Date of Birth is _____, authorize Different Like Me, Inc. to disclose to and/or obtain from:

_____

_____

_____ the following information:
[Insert Name of Person or Title of Person or Organization and contact phone or address]

Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Neuropsychological Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Presence/Participation in Treatment
_____ Speech/Cognitive Therapy Notes
(Evaluations, TX, and Progress Notes)

_____ Therapy and Treatment Notes
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____ Psychotherapy Notes*
*(*Cannot be combined with any other disclosure)*
_____ Summary of notes
_____ Other_____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If the purpose is other than stated above, please specify:

_____

_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Different Like Me, Inc. at 1200 NW 17th Ave. Suite 12, Delray Beach, FL 33445. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date 1 year or as otherwise indicated:_____

Conditions

I further understand that Different Like Me, Inc. will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: Unable to release records

_____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

_____

(Parent, Guardian or Personal Representative Name if not signed by patient)

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ Check here if patient/client refuses to sign authorization

_____

Signature of Staff Witness Date

Different Like Me

Failure to Cancel/ No Show

Patients Name: _____ Date of Birth: _____

I understand that if I fail to attend a scheduled appointment, and fail to cancel the appointment within one full business day prior to the scheduled appointment, I will be responsible for the full fee for all scheduled appointments. Insurance will not reimburse me for this expense nor will Different Like Me Inc bill my insurance for this expense.

I hereby agree to pay the no-show fee as set forth above.

_____

Signature of Patient Date

_____

Signature or Parent, Guardian or Personal Representative * Date

_____

* *If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

Witness' Signature: _____

1200 NW 17th Avenue, Suite 12, Delray Beach, FL 33445 Phone: (561) 270-2280 Fax: (561) 270-2284
E-Mail: alysenovember@differentlikeme.com Web: www.differentlikeme.com

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PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name_____ Date of Birth: _____

Please indicate how you would like staff from Different Like Me, Inc. to contact you. Unless specified below, we will attempt to make contact utilizing any information you have provided to us. Under HIPAA, you have the right to request that communications with you be confidential and by means of your selection except if an emergency arises.

Please contact me as indicated below:

Cell# _____ Home # _____

Work # _____ Email: _____

Mail/Address: _____

_____

_____**You may leave a message on any phone number listed above**

_____You may leave a message with (Names) _____

_____ _____

Signature of Patient or Legal guardian Date

_____

Name of legal guardian signing this form if other than patient

Approved: _____ _____

Signature of Staff Date

1200 NW 17th Avenue, Suite 12, Delray Beach, FL 33445 Phone: (561) 270-2280 Fax: (561) 270-2284

E-Mail: alysenovember@differentlikeme.com Web: www.differentlikeme.com

Different Like Me, Inc.
1200 NW 17th Ave, Suite 12
Delray Beach, FL 33445
561-270-2280

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Client Name: _____
DOB: _____
SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Different Like Me, Inc. Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Different Like Me, Inc.

_____

Signature of Client **Date**

_____

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

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ **Client Refuses to Acknowledge Receipt**:

_____

Therapist Signature **Date**

Different Like Me, Inc. 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.