NEW CLIENT FORM

Client Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

DOB: _____ Gender (Circle One): M F Marital Status (Circle One): S M D W

INSURANCE INFORMATION

Insurance Company Name: _____ Tel No.: _____

Member ID/Policy No: _____ Group No: _____

Primary Insured Name: _____ Primary Insured DOB: _____

Clients relationship to Primary insured: _____ Employer: _____

Authorization No: _____ Referral No: _____

I, the undersigned (or guardian or parent of a minor and the subject of this authorization) hereby authorize Steve Bizier, LCSW to administer treatment. If I am unable to keep an appointment, I agree to give notice of cancellation at least 24 hours prior to the scheduled appointment. I understand that late cancellations and missed appointments will be charged a fee for which I, the client, not my insurance company, will be responsible for.

I authorize payment of medical benefits to Steve Bizier, LCSW for services rendered. I also authorize the release of any medical or other information necessary to process this claim. For additional details, see my Privacy Statement (HIPAA Notice).

Signature: _____ Date: _____

How do you wish to be contacted?

____Phone: ____ (Leave a message with detailed information) ___ (Leave a message with call back number only)
____Email ____ Other (please specify) _____

****A COPY OF YOUR DRIVERS LISCENSE AND INSURANCE CARD IS REQUIRED****

STEVE BIZIER, LCSW 3568 PINE STREET, SUITE 1, JACKSONVILLE FL 32205 TEL: 904-710-7814

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 American Association for Marriage and Family Therapy (AAMFT), American Mental Health Counselor's Association (AMHCA) and National Board of Certified Counselors (NBCC) 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 at our office, 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 clinical social worker and a mental health counselor licensed in the state of Florida it is my practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with HIPAA.

Child, Vulnerable Adult or Elderly Abuse, Neglect, or Exploitation. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child, vulnerable adult, or elderly abuse, neglect or exploitation and/or the suspicion of such. If you are a minor child, or if you have a legal guardian assigned to your care, your parent or legal guardian may also be informed as required by law.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent or without your consent if it is a judge's subpoena), 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 for 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 payers 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 Steve Bizier, LCSW 3568 Pine Street, Suite 1, Jacksonville FL 32205.

**This practice does keep some psychotherapy notes which require a written, specialized and separate authorization for release of information. Psychotherapy notes are separate from your medical record and are not ever made accessible to insurance or EAP companies.*

**Please understand that if you have been seen with any other person during your treatment with me, your record is no longer just your own, it is considered a conjoint file. Therefore, in order to provide a copy of the record to you or to anyone, I will need a release of information procured from each individual that attended your treatment as per Florida Statue § 491.0147(2).*

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. If you ask me to send a copy of my records about you to someone else such as another doctor or even to you, I will do so as quickly as I can and it will never take longer than thirty days after you sign the Authorization form for the records.

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 at Steve Bizier, LCSW 3568 Pine Street Suite 1 Jacksonville, FL 32205 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 1, 2013.

Informed Consent for Treatment

For the purposes of this informed consent for treatment: Steve Bizier, LCSW, will now be abbreviated as follows "SB". The person(s) seeking treatment/being seen in SB's counseling office and/or the parent/the guardian thereof will now be abbreviated/referred to collectively and or interchangeably as "the client".

About Insurance and EAP Companies

(The client always has the right to pay privately for SB's services to avoid the complexities which are described below.)

The client is responsible for contacting the client's EAP or Insurance company to verify and understand SB's status as an "in network" or "out of network" provider for the client's plan, the limits of the client's coverage for mental health/ behavioral health services, as well as the client's co-payments and deductibles, and obtaining preauthorization, if required, as applicable.

The client understands that:

1. Mental health providers are required to submit psychiatric diagnosis and or a "treatment plan" including counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, medication prescription and monitoring, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

2. If an insurance company or EAP elects to audit its particular clients' charts at the therapist's practice they may also discover description of the presenting problem, members within the client's household and quality of relationships, current medical information, therapeutic interventions, and other data in the medical record (e.g. medical session notes).

3. Insurance companies & EAPs reserve the right to audit their member's charts at any time (i.e. the insurance company may audit to monitor compliance for "medically necessary" treatment).

4. Once this information is submitted to the insurance company and/or EAP it becomes a part of the client's permanent medical record and it may be computerized or entered into a national medical information data bank. Once, submitted to the insurance company or EAP, SB has nothing to do with how it's used or maintained by the insurance company or EAP and cannot be held liable for how the information is used thereafter by the insurance company or EAP.

5. If the client does not want to release diagnostic information to the insurance company or EAP the client will not give SB insurance company or EAP information. If the client has already given SB permission to bill the insurance company or EAP and the client no longer wishes to utilize insurance or EAP benefits, the client must advise SB of this in writing. SB cannot be held responsible for information or claims already submitted prior to the client's written request.

6. Each insurance company or EAP have contracted reimbursement rates established with their contracted providers. If a provider chooses to contract with an insurance company or EAP, and the provider is an "in-network" provider, that provider has agreed to accept their reimbursement rates regardless of the counselor's billed rates. The counselor cannot balance bill the client for sessions as per the counselor's contract with the insurance company or EAP. The provider can bill the client for non-insurance or EAP covered services (for example: no show fees).

About Fees & Payments

I, Steve Bizier, LCSW reserve the right to periodically adjust the following fees. The client will be notified of any fee adjustments in advance if known. In addition, these fees may be adjusted by contract with insurance companies or other third party payers or by agreement with Steve Bizier, LCSW.

Please be aware that insurance companies have restrictions on what they will cover and not all issues that may bring someone to therapy are covered by insurance. Whenever possible I will notify the client ahead of time if I become aware of said restrictions.

My billable rates are as follows:

☐ Diagnostic Intake/Interview 60-90 min + administrative time (90791)	$150.00
☐ Individual Psychotherapy 45 minutes (90834)	$ 95.00
☐ Conjoint/Family Psychotherapy 45-50 min (90847)	$ 110.00
☐ Family Psychotherapy without the Client Present 45-50 min (90846)	$ 120.00
☐ Individual Psychotherapy for 60 minutes (90837)	$ 135.00

Clients not utilizing insurance or EAP benefits qualify for a courtesy cash discount due to our office not having the extra administrative tasks of working with the insurance company or EAP companies.

Those rates are as follows:

☐ Diagnostic Intake/Interview 60-90 min + administrative time (90791)	$150.00
☐ Individual Psychotherapy 45 minutes (90834)	$ 85.00
☐ Conjoint/Family Psychotherapy 45-50 min (90847)	$ 95.00
☐ Family Psychotherapy without the Client Present 45-50 min (90846)	$ 95.00
☐ Individual Psychotherapy for 60 minutes (90837)	$ 105.00

Payment (regardless of whether it's a copayment, coinsurance, deductible, or private payment) **is due at the time of session unless otherwise discussed & agreed upon ahead of the session in question. If the client is using out of network benefits, the client is responsible for paying the full fee at the time of service.**

The client is ultimately responsible for the payment of fees, not the insurance company or EAP. Should the insurance company or EAP elect not to pay for any reason (i.e. the client did not attain an authorization for sessions, etc.). **These fees will be due within 30 days of the insurance company's or EAP rejection.**

I accept cash, venmo, apple pay, credit card or PayPal.

Collections - The client understands that if the client does not fulfill the client's financial obligations within 30 days (unless otherwise arranged), I, Steve Bizier, LCSW have the right to pursue payment via a collections agency, small claims court, and/or I, Steve Bizier, LCSW have the right to report outstanding balances to the credit bureaus.

The client understands that failure to pay fees will result in immediate terminations of treatment without exception.

Other fees: Fees for the following events, should they occur are:

$250 an hour: Should I, Steve Bizier, LCSW be asked to appear in court on the client's behalf via a subpoena (this includes travel time, wait time, deposition, document/testimony preparation time, attorney meetings, and/or court related telephone calls). If I am forced via subpoena to appear in court on the client's behalf, the client agrees to pay upfront and prior to my court appearance a non-refundable retainer fee in the amount of $1000 (which represents 4 hours of service).

$250 an hour: Should I, Steve Bizier, LCSW be required to perform court-related services in excess of the initial 4 hours, the client acknowledges that he/she will be billed $250/hour for the additional court-related services. The client acknowledges that this document serves as a contract for professional services so written and agreed to between the client and Steve Bizier, LCSW (not the attorney, insurance company, or any other party). Client will be held liable for full payment of Steve Bizier's court related fees.

$1 per page should the client's records be requested to be faxed, mailed, &/or emailed to other professionals/parties regarding the client's care. Charges associated with these services will be due prior to the other professionals/parties receiving said documentation.

Postage to send documents to other parties.

Appointment Cancellations, Reschedules and No Shows

The client understands appointments must be cancelled or rescheduled with a minimum of 24 hours' notice. Notice of cancellations and reschedules with only 24 hours' notice need to be made via telephone and by leaving a voicemail. The client understands that if the client does not provide 24-hour notice or the client doesn't show up for an appointment, without a valid excuse, the client will be charged $25 for the first offense and full session fee thereafter. If this happens more than twice, SB reserves the right to terminate the therapeutic relationship and will provide referrals to other appropriate clinicians and the client will be responsible for paying the resulting fees for the offending appointment cancellation, reschedules or no shows.

About Methods of Communication & Protection of Privacy

Telephone: SB maintains a confidential voice mail associated with his office phone (904-710-7814). SB strongly recommends that clients utilize telephone communication as the primary mode of communication with SB for the purposes of scheduling appointments and/or holding brief and infrequent discussions regarding treatment.

About Social Networking

Social Networking Sites: SB does not accept "friend" requests from current or former clients on social networking sites, such as Facebook, due to the fact that these sites can compromise clients' confidentiality and privacy. For the same reason, SB requests that clients do not communicate with him via any interactive or social networking web sites.

Steve Bizier, LCSW is responsible for:

- Billing for services provided to the appropriate, designated party. For example, EAP or insurance company or directly to the client if the charge is not an insurance billing item.
- Explaining any charges as necessary.
- Going over the client's goals, symptoms, and/or diagnosis with clients and suggest various types of treatment.
- Explaining the advantages & risks of therapy as necessary and/or appropriate.
- Ensuring that another licensed therapist will be made available to the client via telephone in the event of a client having an urgent need when I, Steve Bizier, LCSW go on vacation or have some type of other situation in which I'd be unreachable or unavailable for more than 24 hours.
- Adhering to all state & federal laws pertaining to the practice of mental health and clinical social work
- Adhering to all codes of ethics of any professional association I, Steve Bizier, LCSW am involved with
- Keeping scheduled appointments with clients unless there is an unforeseen emergency – in which case clients will be informed as soon possible.
- Informing clients in writing if there are to be any changes to this agreement.

The Client's Responsibly is to:

- Understand mental health benefits (for example: deductible, co-pay, co-insurance, authorization requirements, etc.) and to notify SB of any changes to the client's benefits as soon as the client is aware of such changes.
- Pay for services not covered by the client's insurance unless restricted by contract.
- Notify SB of any changes to the client's address, phone number(s), medical conditions, medications, employment, or symptoms.
- Be on time for appointments and call if running late.
- Schedule appointments with full intention of keeping them.
- Call 911 if having a life threatening emergency (or if appropriate the client can go to the nearest Emergency Room)
- Be responsible for and be active in treatment.
- Allow for assessments on a regular basis as required to monitor my mental health condition to ensure that treatment is still required and is appropriate.
- Ask questions if not understanding the treatment plan or any aspect of treatment.

Acknowledgement of the Receipt of the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices (NPP) – Effective 2013

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Steve Bizier, LCSW, Notice of Privacy Practices. I understand that if I have any questions regarding the Notice of my privacy rights, I can contact Steve Bizier, LCSW at (904) 710-7814.

_____X_____

Adult Client Name or Guardian of Minor (Print) Signature

Date: _____

Acknowledgement of Agreement to Informed Consent for Treatment

I hereby acknowledge that I, the undersigned, the client, have had the opportunity to review and ask any questions that I, the client, may have about the Informed Consent for Treatment. By signing below, the client is agreeing to adhere to all of its content and is voluntarily choosing to enter into a therapeutic relationship with Steve Bizier, LCSW and may terminate services at any time.

_____ X _____

Adult Client Name or Guardian for Minor (Print) Signature

Date: _____

☐ Client or Guardian refuses to Acknowledge Receipt

_____ _____

Signature of Therapist Date