Christina Guidorizzi, LCMFT

REGISTRATION (please print)

Today's date:	

CLIENT INFORMATION

Last name:	First name, MI:	❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.
Date of birth:	Gender: ❑ M ❑ F	
Street Address:	Apt:	Home Phone:
City:	State:	Zip code:
If client is a minor, name of Responsible Party/Guardian:	Responsible Party's phone no.: ( )	

INSURANCE INFORMATION

We cannot guarantee insurance coverage by your insurance carrier. The information below will assist us in determining if some of the expenses are reimbursable by your insurance carrier. Please provide your insurance card so that we may take a photocopy.

Primary Insurance Company:	ID#	Group#	Social Security No.:
Name of Insured (if not the client)	Relationship to Insured:	Insured's DOB:	Insured's Gender: ❑ M ❑ F
Street Address	Apt:	Home Phone:	
City, State, Zip	Employer:	Occupation	

Secondary Ins. Carrier (if applicable)	ID#	Group#	Social Security No.:
Name of Insured (if not the client)	Relationship to Insured:	Insured's DOB:	Insured's Gender: ❑ M ❑ F
Street Address	Apt:	Home Phone:	
City, State, Zip	Employer:	Occupation	

AUTHORIZATION AND RELEASE

	I certify the above information is true and correct to the best of my knowledge. I certify that I (or my dependent) have insurance coverage and assign directly to ***Christina Guidorizzi*** all insurance benefits, if any, otherwise payable to me for services rendered. I understand and agree that I am ultimately responsible for payment – and that at this time services rendered may not be covered by my insurance. I understand that I am financially responsible for all charges whether or not paid by insurance.
	I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that billing is done by a third-party and that I may contact them with questions regarding my account.

_____ _____ _____

Client / Responsible Party Signature | Relationship | Date

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 IT CAREFULLY.

If you have any questions about this Notice please contact the Privacy Officer of our practice, Christina Guidorizzi, LCMFT

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by calling our office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your provider, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your provider's practice.

Following are examples of the types of uses and disclosures of your protected health information that your provider's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other providers who may be treating you. For example, your protected health information may be provided to a provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another provider or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your provider, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your provider.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: *We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.*

Public Health: *We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.*

Communicable Diseases: *We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.*

Health Oversight: *We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.*

Abuse or Neglect: *We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.*

Food and Drug Administration: *We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.*

Legal Proceedings: *We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.*

Law Enforcement: *We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.*

Coroners, Funeral Directors, and Organ Donation: *We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.*

Research: *We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.*

Criminal Activity: *Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.*

Military Activity and National Security: *When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.*

Workers' Compensation: *We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.*

Inmates: *We may use or disclose your protected health information if you are an inmate of a correctional facility and your provider created or received your protected health information in the course of providing care to you.*

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: *Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.*

Others Involved in Your Health Care or Payment for your Care: *Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.*

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your provider and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If your provider does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your provider. Restriction requests must be made to your provider in writing.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your provider amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we

deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer at (301)_495__-_6393_____ or the mailing address of our office: __8720 Georgia Avenue, Silver Spring, MD 20910_____

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for further information about the complaint process.

This notice was published and becomes effective on **09/15/2014**

Acknowledgement of Receipt
Of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Christina Guidorizzi ‘s health care operations. The Notice of Privacy Practices also describes my rights and Christina Guidorizzi ‘s duties with respect to my protected health information. The Notice of Privacy Practices is available from Christina Guidorizzi.

Christina Guidorizzi reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent in the mail or asking for one at the time of my next appointment.

EMERGENCIES

If you are in need of immediate attention, please call 911 or go to the nearest hospital emergency room.

The number to leave a message is (301) 495-6393. If you need to contact me promptly, please call (301) 742-2595. I will return calls in a timely manner, between 9 a.m. and 7 p.m. Monday-Friday. I will return weekend calls on Monday, unless Monday is a holiday.

My aim is to be available to you should an emotional emergency arise. I check my phone periodically for messages, even after hours. Therapeutic calls are billed pro-rated at the regular fee

_____ _____
Signature of Client or Client Representative

_____ _____
Name of Client (s)

_____
Name of personal representative & description of authority (guardian, etc.)

_____
Date

STATEMENT OF CLIENT RIGHTS

YOU HAVE A RIGHT TO:

1) Be treated with respect, courtesy and competence.
2) Be given an assessment of the problem and what alternatives exist for dealing with it.
3) Be shown respect for your religious beliefs, social views, and cultural background. Clients can receive translation if needed.
4) Share in setting goals and discussing treatment and the number of sessions.
5) Disagree with the course of treatment.
6) Be told the reasons for transfers, referrals, and discontinued sessions.
7) Be told that the mental health professionals are required by law to share information with the appropriate authorities if there is a reason to believe:

a) A child or vulnerable adult is being physically, sexually, or emotionally abused or neglected.

b) A client is using alcohol and/or controlled substances (cannabis (marijuana), cocaine, heroine, phencyclidine, methamphetamine, amphetamine, or their derivatives) during pregnancy.

c) A client is planning to seriously hurt someone, including himself or herself, or needs emergency help.

8) Know that records are kept by Christina Guidorizzi, LCMFT staff on each visit. Client files belong to Christina Guidorizzi, LCMFT and cannot be removed, but they may be examined, subject to confidentiality issues described below.
9) Expect confidential handling of records. However, the following are situations when others may receive information about a client without a specific release:

a) Christina Guidorizzi, LCMFT staff may need to access a file for professional purposes.

b) A court order may require the release of the information.

c) Representatives or accrediting boards or Qualifying Assurance teams may review records as they monitor performance.

d) Parents may see a minor's file. Minor's may request and exception.

YOU ARE RESPONSIBLE FOR:

1) Taking an active part in counseling by sharing ideas and asking questions.
2) Working with your therapist to create a specific treatment plan.
3) Being open to looking at problems in new ways and trying new behaviors.
4) Notifying the Christina Guidorizzi office 24-hours in advance if you cannot keep a therapy appointment, and/or one week in advance of a psychiatric medication or psychological testing appointment. (Failure to keep appointments may mean we can no longer provide services to you.)
5) Being informed of the benefits offered by your insurance plan, and paying any fees that your are responsible for.
6) Respecting the privacy of other people served by Christina Guidorizzi.
7) Making a complaint if you are not satisfied with the services you received.
8) Understanding that court appearances are not covered under insurance plans, and that if your therapist, psychiatrist or clinical nurse specialist is subpoenaed to testify on your behalf, you will be responsible for all costs relative to that subpoena. No court appearances will occur without written subpoena or court order.

I HAVE READ AND UNDERSTAND MY RIGHTS AND RESPONSIBILITIES LISTED ABOVE.

_____/ _____ _____

Signature of Client or Parent / Guardian Date

Signature of Representative:

_____ Date: _____

BILLING POLICY

TWO PAYMENT OPTIONS ARE AVAILABLE- CASH/CHECK OR INSURANCE:

CASH ACCOUNTS:

Clients who elect to pay cash may receive a discounted rate for therapy fees. This will be decided on a case by case basis at the first appointment. To receive the cash discounted rate, payment must be made at each appointment. The cash account can be set up when there is no insurance coverage for you or you do not wish your insurance to be billed. Payments should be made via cash or check to: __CHRISTINA GUIDORIZZI___ at the time of service.

INSURANCE:

IN-NETWORK INSURANCE

Christina Guidorizzi_ is currently in-network with *Care First Blue Cross, Blue Shield and Aetna*

- In most cases we will be able to bill your insurance company directly. However, this is a service we provide for you and it carries no guarantee of payment. Your insurance plan is a contract between you and your carriers and you always remain responsible for the bill.
- Most insurance plans do not cover 100% of charges. If you have a co-payment, it is due at the time of your appointment. Please make checks payable to your therapist.
- If your charges are not paid by your insurance due to a deductible, an unpaid copay or termination of your coverage, you are responsible for those charges and will be billed for those amounts.
- It is your responsibility to notify your therapist whenever your insurance changes. We may not be a provider for your new insurance plan.
- Insurance requires a medical diagnosis for each claim; your plan may exclude certain diagnoses. It is important that you are well-informed regarding your policy as ultimately it is your responsibility.
- Some insurance plans or managed care contracts require treatment plans or contact from your therapist to pre-certify or continue treatment. You will be asked to sign a form granting your therapist permission to make this contact in order to use your insurance benefit.

OUT-OF-NETWORK INSURANCE

Your therapist is considered out-of-network for all remaining insurance carriers. Please check with your insurance company about coverage for mental health services with a non-participating provider. We cannot guarantee that your care will be covered by your insurance carrier.

- Clients who have co-pays will be asked to pay the equivalent of their co-pays. i.e. if your co-pay is $25, you will pay $25 as your cash price at the time of service.
- Clients who have deductible or co-insurance plans where no co-pay is listed will pay $130 as your cash price at the time of service.

If your therapist becomes in-network with any other carriers, and following your insurance carriers guidelines, your account will automatically be submitted to the insurance plan, as outlined below, for all dates of service on and after the effective date of in-network status. If your insurance allows retroactive submission of past claims, we will also do that on your behalf.

Payments should be made via cash or check to: **Christina Guidorizzi,** at the time of service for all co-pay amounts and out-of-network arrangements.

You may receive reimbursement checks and explanations of benefits (EOB) directly. In this instance, we will not get them here at the office. You will need to:

- Sign the check over to your provider
- Bring us a copy of your EOB

If we do not receive these items to track your claims, we will have to bill you for the full amounts of your services.

PAYMENT FOR SERVICES:

You are responsible for your charges. Benefit information received from your insurance plan is an estimate of benefits, not a guarantee of payment. Statements will be sent to you if there is a balance due. Interest of 1.5% per month (18% annual) will be added to client balances over 30 days old. If you ever have a question about a bill which you have received please contact our billing office at the number listed on your statement.

DELINQUENT ACCOUNTS

When it becomes necessary to resolve a past due amount, a collection agency may be contacted. Any fee, charges or commissions incurred as part of the collections effort will be added onto the amount and will be your responsibility as well.

LATE CANCELLATIONS AND NO SHOWS

24-hour notice must be given or a $ 65 fee will be charged to your account. Failed appointments may jeopardize continued service with your therapist. Any requests for exception to a late cancel or no show charge need to be addressed in person or by telephone.

CONSENT TO RELEASE / EXCHANGE INFORMATION

I authorize any release of information as required by my insurance company, QRC or provider to process my claims. I permit a copy of this authorization to be used in place of the original. This information may include: place of service, diagnosis, type of treatment, medical background and relevant history, and information about treatment. I understand that in some cases the insurance company requires case notes or a written summary of my treatment, this information will be provided to my insurance company.

I authorize Christina Guidorizzi_ to be paid directly by my insurance carrier.
I authorize the therapist's billing office to release billing information or date of service to the following individuals (list the name(s) of any individuals other than yourself who may be allowed to receive this information, such as a spouse):

_____

_____

_____

Your signature indicates that you agree to abide by this Billing Policy in its entirety.

Client or Parent/Guardian Signature: _____ Date: _____
(Client or responsible party must be 18 years of age or older.)

_____ Initial here if you would like a copy of this policy.