Barbara F. Stern, PhD
450 Royal Palm Way, Suite 400
Palm Beach, Fl. 33480

PATIENT INFORMATION

Please Print

Name: _____ D.O.B: _____

SSN: _____ (circle) Male Female

Address

Street: _____

City: _____ State:_____ Zip: _____

Billing Address (if different):

Street: _____

City:_____ State:_____ Zip: _____

Confidential Contact Information

Email _____ Phone _____ Cell _____

In Case of Emergency Contact _____ Phone _____

Who referred you _____

Primary Care Physician _____ Phone _____

Address _____ Fax _____

Patient Initials _____

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Other Specialists You See _____

MEDICATION INFORMATION

Allergies_____ / No Known Allergies

Current Medications:

Medication	Dosage	Times a Day	Side Effects	Prescribed By

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INFORMED CONSENT FOR SERVICES

Welcome to my practice. This contract governs the way my practice operate. Please take your time to review it carefully. This document is lengthy because it includes my consent, an arbitration agreement, and a notice of privacy practices required by HIPPA.

APPOINTMENTS: All appointments are 1 hour. The office hours are 10am to 7pm, M-F. The office manager is available to answer calls 9am to 6pm, M-F. I will return a call the same day that I receive it. Emergency appointments are arranged within 24 hours. If an emergency arises that cannot wait, please call 911 instead or a crisis hotline.

At the time of booking your appointment, you were asked to provide a credit card number. You have consented to my charging for missed appointments on that credit card. Appointments must be cancelled or rescheduled **48 hours in advance** to avoid being billed for the service scheduled. Missed appointments are charged the full rate. If you are more than 15 minutes late to your scheduled appointment time, you will have to reschedule for another time and pay for both appointments. This is not a punishment. You purchase my time, and I will not double book. If I did not charge for that time, I would not be able to provide my level of service. You may have a phone session if you are unable to reach the office in a timely manner.

Video-conferencing (Facetime, Skype) is the next best option after face-to-face contact. Please keep in mind that it does not show all body movements (e.g., gait) and many non-verbal forms of communication cannot be

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seen.

FEES: I do not take insurance. Payment is due on the day of service. Any time spent on your care is billed at the same hourly rate. Some examples include: speaking on the phone, charting, texting, emailing, writing letters, reports, reviewing records, traveling to house calls, and communication with family, friends, attorneys or other physicians. You are responsible for all collection fees. Each month the bill is late, a $30 billing fee or 5% of the balance (whichever is greater) will be added to your bill.

FORENSIC FEES: Forensic work is billed at a higher rate. This includes assessments, preparing for depositions, depositions, travel time, court time, writing reports, etc. The same 48-hour cancellation policy applies regardless of who is responsible for the cancellation.

LEGAL CIRCUMSTANCES: If legal involvement is anticipated in your case, even if you are not looking for a forensic psychiatrist (e.g. you are applying for disability, receiving disability, receiving damages for emotional distress or you will be needing ongoing reports to the court or a licensing agency about your treatment), this should be stated when scheduling the appointment. This will result in a far better outcome for you, mainly because the level of documentation must be tailored for these purposes. Routine psychiatric and medical documentation can be misinterpreted and even detrimental during litigation.

MEDICARE: I have opted out of Medicare. Thus, you cannot receive any reimbursement from Medicare for the fees you pay me, and this may mean you cannot get reimbursement from your Medicare supplemental plan (Medigap) as well. This also means you have entered into a private contract with my practice. You must notify my office that you are a Medicare beneficiary or if you become a Medicare beneficiary while under my care so you can sign a contract acknowledging the above every two years. This does not affect any of your claims with other physicians, pharmacies, laboratories or hospitals.

HOUSE CALLS: I provide house calls to patients who are housebound or require in-home therapy. When I travel to see a patient, my time is billed at the same hourly rate.

OUT OF STATE PATIENTS: The doctor-patient relationship of all my patients is based in Florida, and all patients must have at least one encounter with the doctor in Florida. This is a requirement even though I am licensed in Massachusetts.

ELECTRONIC COMMUNICATIONS: Communication via email, text, instant messenger, fax, phone, voicemail, and video/web conferencing can be used. These forms of communication cannot be guaranteed to be secure, confidential, and/or reliable. Additionally, the clinician may choose not to respond to the question outside of an appointment. I cannot stress enough that face-to-face contact through a scheduled appointment is the only guaranteed way to communicate with the clinician. All electronic communications can be added to your medical records and you will be charged for the time it takes to paste it in there. Social media outlets are not a viable method of communication. Please keep the username and passwords for your emails secure and confidential or do not utilize them with us at all. The same rule applies for the patient username and password for my records.

SESSION NOTES: The purpose of my notes is to enable continuity of care between office visits. I am not writing for any audience other than the clinician. This means I am not writing for insurance companies, social security or attorneys. If you do not want there to be any record of the content of your sessions beyond the fact that you attended, you may request this in writing. It is at the clinician's discretion if I feel comfortable treating you with no notes. A more practical alternative is to use a pseudonym on your chart.

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PRIMARY CARE: All patients need to be under the routine care of a primary care physician. Even if you are seeing a psychologist once a week, it does not ensure that your routine health maintenance is being addressed. In some cases, with your permission, it may be beneficial for the provider to be in contact with other physicians and or who prescribe medications.

ARBITRATION AGREEMENT: Arbitration means you waive your right to a jury trial. Due to the high costs of medical malpractice insurance and litigation, this office requires every patient to sign an arbitration agreement. This means that all potential disputes are resolved through arbitration and not in court. This is mandatory for anyone who chooses to be a patient in my practice. In the event of a dispute of any nature arising between the parties or their heirs at any time, as a result of the clinician providing services, advice, treatment, informed consent, tests, and procedures whether in person or by phone, text, writing, internet, in the home, office, hospital or otherwise, the parties hereto agree to submit the dispute to binding arbitration under the rules of the Independent American Arbitration Association. An award rendered by the arbitrator(s) shall be final and binding upon the parties and judgment on such award may be entered by either party in the highest court having jurisdiction. Each party hereto specifically waives his/her right to bring the dispute before a court of law and stipulates that this agreement shall be a complete defense to any action instituted in any local, state or federal court or before any administrative tribunal.

CHANGES TO THIS NOTICE: I reserve the right to change this notice. I reserve the right to make the revised or changed notice effective for health information I already have about you, as well as any information I receive in the future. I generally update all of my forms once per year. This Agreement shall not be amended except by written instrument executed by both parties hereto. Should any provision of this Agreement be declared void or ineffective by virtue of any state or federal statute or regulation, or decision of any court or regulatory authority, such declaration shall not invalidate any of the provisions of this Agreement that otherwise remain in full force and effect.

NOTICE OF PRIVACY PRACTICES (HIPAA)

CONFIDENTIALITY: Your information is generally protected and kept confidential. However, there are certain circumstances under which information may be released to other parties without your permission. It is your responsibility to review the HIPAA website for a complete list of disclosures at www.hhs.gov/ocr/privacy/index.html. The following is a partial list of my notice of privacy practices.

I am required by law to maintain the privacy of protected health information, give you this notice of my legal duties and privacy practices regarding your health information, and follow the terms of my notice that currently is in effect.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways I may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, I will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to my office manager.

For Treatment. I may use and disclose Health Information for your treatment and/or to provide you with treatment-related health care services. For example, I may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside my office, who are involved in your medical care and need the information to provide you with medical care. I may contact you to remind you that you have an

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appointment with me. I also, may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

For Payment. I may use and disclose Health Information so that others or I may bill and receive payment from you, an insurance company, or third party for the treatment and services you received. For example, I may give your health plan information about you so they will pay for your treatment. When appropriate, I may share Health Information with a person who is involved in your medical care or payment for your care (e.g., family, close friend).

For Health Care Operations. I may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure my patients receive quality care and to operate and manage this office. For example, I may use and disclose information to make sure the psychiatric care you receive is of the highest quality. I, also, may share information with other entities that have a relationship with you (e.g., your health plan) for their health care operation activities.

1. **Insurance**: If you are using health insurance for reimbursement of your visits, the information enters into the medical information bureau (www.mib.gov), which may have consequences when applying for other insurance policies (e.g., health, life, long-term care, disability). If your employer provides your health coverage, they may have access to your information as well.
2. **Out of pocket payments:** If you paid out-of-pocket for a specific item or service and did not seek reimbursement from your health insurance, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and I will honor that request.
3. **Payment by another person**: If another person is paying for your visits, they have the right to know if you have attended the sessions.
3. **Credit card companies**: If you contest a visit with a credit card company, they will have access to the documentation from that visit.
4. **Social security**: If social security requests your records, I will send the entire chart.
5. **Court order/subpoena/litigation**: Clinicians are required to provide information in response to court orders or subpoenas. Additionally, if treatment is provided as a result of a court order, I am required to release certain information. It would be your attorney's responsibility to claim privileges associated with the disclosure of your records. It should be noted that all electronic communication is potentially discoverable during litigation.
6. **Consultation**: Your clinician may consult with other professionals regarding your case. Please indicate in writing if you would like restrictions placed on what can be shared.
7. **Abuse/neglect**: When there is reasonable suspicion of current or previous child, adult, elderly, or disabled abuse/neglect, clinicians are required to report this information to certain authorities, persons, and agencies.
8. **To avert a serious threat to health or safety**: I may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public. Disclosures, however, will be made only to someone who may be able to help prevent the threat.
9. **Death**: After your death, your information is confidential for fifty years. However, records may be reviewed by the executor of your estate. You can request in writing that your records be purged after your death. This request needs to be discussed with your estate attorney and be notarized. It is up to the clinician's discretion whether or not to comply with this request.
10. **Business associates**: I may disclose Health Information to my business associates that perform functions on my behalf or provide me with services if the information is necessary for such functions or services.

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For example, I may use another company to perform billing services on my behalf. All of my business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

11. **Data breach notification purposes:** I may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.
12. **Lawsuits and disputes**: If you are involved in a lawsuit or a dispute, I may disclose Health Information in response to a court or administrative order. I also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
13. **Public health risks**: I may disclose Health Information for public health activities. These generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; and a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. I will only make this disclosure if you agree or when required or authorized by law.
14. **Coroners, medical examiners and funeral directors**: I may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. I also may release Health Information to funeral directors as necessary for their duties.
15. **Inmates or individuals in custody**: If you are an inmate of a correctional institution or under the custody of a law enforcement official, I may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.
16. **Workers' compensation**: I may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
17. **Military and veterans**: If you are a member of the armed forces, we may release Health Information as required by military command authorities. I also may release Health Information to the appropriate foreign military authority if you are a member of the foreign military.
18. **Health oversight activities**: I may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
19. **Organ and tissue donation**: If you are an organ donor, I may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation and transplantation.
20. **Couples and family sessions**: I encourage family involvement in your care. If you are being seen in couples or family therapy, or if a family member becomes involved in your individual care, the clinician will have to exercise discretion when disclosing information to active participants but cannot promise absolute confidentiality.
21. **Minors**: Laws regulate that certain information may or may not be shared with the minor's legal guardian/parent. This also may be up to the discretion of the treatment provider, especially if the disclosure would negatively affect treatment progress with the patient.
22. **Natural disasters**: I cannot be held responsible for information that may become exposed as a result of inclement weather.
23. **Law enforcement**: I may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2)

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limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, I are unable to obtain the person's agreement; (4) about a death I believe may be the result of criminal conduct; (5) about criminal conduct on my premises; and (6) in an emergency.

RIGHT TO REQUEST CONFIDENTIAL COMMUICATIONS: You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that I contact you by email or at work. To request confidential communications, you must make your request in writing to the office manager. I will accommodate reasonable requests.

RIGHT TO INSPECT AND COPY: You have the right to inspect and copy only part of the medical information that is used to make decisions about your care. This includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. Of my records, you only have access to the mental status exam and diagnosis. The psychiatric diagnosis is a constant work in progress that is refined the more time the clinician spends with the patient. An initial diagnosis is frequently provisional. I may black out any other components of the note. An alternative, recommended option is to request a note summarizing your care by my practice. I will charge you the usual fees for the time it takes to deal with your request. In order to inspect and copy medical information, you must submit your request in writing to the office manager. I have up to 30 days to make your protected health information available to you. I may deny your request to inspect and copy under unique circumstances. If you are denied, you may request the denial be reviewed and another licensed health care professional chosen by this practice will review your request and the denial. I will comply with the outcome of that review. I recommend you only review your records in the presence of your clinician after careful discussion.

RIGHT TO AMEND: If you feel that the Health Information I have is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. You may also write an amendment to the clinician or the office manager and we will add it to your chart. I cannot erase notes that have already been written.

RIGHT TO GET NOTICE OF A BREACH: You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information I disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that I not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request in writing to your clinician or office manager. I am not required to agree to your request unless you are asking me to restrict the use and disclosure of your Protected Health Information to a health plan for payment or for health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If I agree, I will comply with your request unless the information is needed to provide you with emergency treatment.

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SENDING RECORDS: It is not a good idea to release your complete psychiatric records to anyone for any reason. Routine psychiatric notes are not written for anyone other than the author and are subject to misinterpretation. Your clinician can prepare a summary of your treatment or a current psychiatric evaluation answering a specific question to a consultant. I will send a complete copy of your records to social security disability with your consent. A copy can be sent to another clinician one time if you are transferring care, and they want to read your entire record. Most clinicians I know would prefer a treatment summary. If you release your entire record, be aware that it may take time to paste all past electronic communications into your chart, and you will be charged for the time it takes to paste them into the record. The fee for copying and if necessary blacking out psychotherapy notes is $1 a page. I will charge you the usual fees for the time it takes to deal with your request. In the event your account is past due, records will not be released until the account is brought up to date.

RIGHT TO AN ACCOUNT OF NON-STANDARD DISCLOSURES: You have the right to request a list of the disclosures we made of medical information about you for purposes other than treatment, payment, or health care operations or for which you provided written authorization. You must submit your request to our practices and indicate the time period for which you want to receive a list of disclosures that is no longer than six years. This excludes the Department of Social Security.

PUBLICATION: I may use information from your records for research, teaching, and publication purposes. I will make it anonymous and keep your identity protected. If you are entered into a prospective clinical trial, a separate consent will be required.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT:

1. Individuals involved in your care or payment for your care: Unless you object, I 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, I may disclose such information as necessary if I determine that it is in your best interest based on my professional judgment.

2. Disaster relief*:* I may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. I will provide you with an opportunity to agree or object to such a disclosure whenever I practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES:

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

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1**. Uses and disclosures of Protected Health Information for marketing purposes; and**

2. **Disclosures that constitute a sale of your Protected Health Information**

Other uses and disclosures of Protected Health Information not covered by this notice or the laws that apply to me will be made only with your written authorization. If you do give me authorization, you may revoke it at any time by submitting a written revocation to my office manager and I will no longer disclose Protected Health Information under the authorization. However, disclosure that I made in reliance on your authorization before you revoked it will not be affected by the revocation.

I have reviewed the information contained within this consent and have been given the opportunity to ask questions regarding the information. I am physically and mentally competent to give consent. I understand that by signing this, I am giving my consent knowingly and voluntarily without any element of force, deceit, duress, or any other form of constraint or coercion.

I understand that my treatment is contingent upon my consenting to this document without modifications. I understand that either myself or someone legally authorized to make health care decisions on my behalf may revoke my consent in writing before or during treatment, except to the extent that our practices have taken all incurred costs of treatment. In signing, I agree to comply with the information contained within, without reservation.

_____ _____

Patient or Guardian's Signature Date

CREDIT CARD AUTHORIZATION FORM

Appointments will not be scheduled until the entire consent form has been completed along with a credit card on file to secure the appointment time.

The card provided will be used for the appointments, sessions, and services. I understand that this credit card will be charged, unless I provide another form of payment prior to the appointment. It is my responsibility to inform the office of any payment changes I need to make *prior* to the visit. The cardholder must understand and agree with offices guidelines and policies listed in addition to authorizing this office to bill for time scheduled (*fee for services*) to include no-shows of scheduled appointments. To provide services, the cardholder of the credit card must agree not to dispute any credit card/ debit card charges for services provided.

I herby authorize the practice of Barbara Stern, PhD to charge the following described Credit Card, and have been duly informed of the policies and procedures of her practice. I herby am aware of the treatment and charges and agree to assume financial responsibility for the treatment. I am aware that the fee is $200.00 per hour.

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Patient or party responsible for payment other than the patient: I consent to the billing and payment policy and take responsibility for this patient's bill. I understand this card will be charged for services or for missed appointments without 48 hours cancelation notice.

Patient Name: _____

Party Responsible for Treatment (other than patient):_____

Credit Card Type: MasterCard Visa Discovery Amex Other_____

Card Holder's Name On Card: _____

Credit Card #: _____ Exp. Date: ____/_____ V-Code: _____

Cardholder's Contact and Billing Information:

Street Address: _____Suite/Apt. No.: _____

City: _____ State/Province/District: _____Zip Code: _____

Billing Address Phone: _____ Alternate Phone: _____

Email Address: _____

Signature: _____ Date: _____

Printed Name: _____

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