

Lisa D. Piechowski, Ph.D., ABPP

Clinical & Forensic Psychology

Diplomate in Forensic Psychology • American Board of Professional Psychology

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Licensed Psychologist in Connecticut, Massachusetts, & New York

Hello! Welcome to my practice. I look forward to meeting with you and working with you to address your concerns. In this packet you will find some useful information as well as some forms to fill out and bring to your first session.

Before your first session, please call your insurance company (if you intend to use insurance benefits) in order to verify the extent of your coverage, the amount of your co-pay, and to obtain an authorization number (if needed). Please complete the enclosed Patient Information Form and the Consent & Fee Agreement Form and bring these with you to your first appointment. You will also need to bring your insurance card so I can make a copy of it. I will collect your co-pay (cash or check) at the end of every session.

I will try to schedule sessions as conveniently as possible for you. If you need to change a scheduled appointment, please do so as soon as you can so that I can make the time available for someone else. One of the best ways to reach me to reschedule is by email (lpiechphd@sbcglobal.net). Please note that I do charge a \$50 fee if you don't show up for an appointment or cancel the same day. This fee cannot be billed to your insurance and it will be your responsibility to pay. I do try to be flexible and I never charge for missed appointments in the case of an emergency or other unavoidable situation.

If you need to speak to me for any other reason between sessions, I will try to return your call within twenty four hours. Please note that I am not available for emergencies in the evenings or on weekends. In the case of an emergency, you should go to your nearest hospital emergency room or call 911.

Please feel free to contact me if you have additional questions. I look forward to meeting you at your first session.

Yours truly,



Lisa D. Piechowski, Ph.D., ABPP

PATIENT INFORMATION

DATE _____ MALE FEMALE SS #: _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (H) _____ (W) _____ (C) _____

E-MAIL _____

DATE OF BIRTH _____ AGE _____

MARITAL STATUS: MARRIED SINGLE WIDOWED DIVORCED

EMERGENCY CONTACT: _____

PHONE _____ RELATIONSHIP _____

REFERRED BY _____

PRIMARY CARE PHYSICIAN _____

DO I HAVE YOUR PERMISSION TO CONTACT YOUR PHYSICIAN? YES NO

INSURANCE INFORMATION

CHECK HERE IF YOU WILL SELF-PAY

CO. NAME _____ INSURED _____

SELF SPOUSE PARENT

SS# _____ DOB _____ EMPLOYER _____

ID# _____ GROUP # _____

INFORMED CONSENT FOR TREATMENT AND FEE PAYMENT AGREEMENT

Please read this carefully before signing. If you do not understand any aspect of this agreement, please ask about it before signing. This document describes important information about psychological treatment and evaluation as well as some of your rights, responsibilities, and expectations regarding confidentiality.

You have requested my services for psychological evaluation and/or treatment. I am a licensed psychologist in this state and I want to provide you with the best possible psychological services. Please feel free to ask me any questions at any time about your treatment.

Anything you share with me will remain confidential with the following exceptions. I am mandated to report abuse of minors or elderly persons. If I believe you are in imminent danger of seriously harming yourself or someone else, I will take action necessary to protect you or your intended victim. If you become involved in some types of legal actions, I may be court-ordered to testify or turn over records to the court. Insurance and managed care companies often require the release of certain information in order to pay for treatment (see below for more details). Additional information is found in my description of Privacy Practices that has been provided to you.

The psychological services you receive are provided on a fee for service basis. The cost is as follows: 1st session: \$175 (50 minutes); subsequent sessions: \$150 (50 minutes); psychological testing: \$175 per hour; and report preparation/consultation: \$150 per hour. **A fee of \$50 is charged for missed appointments or appointments canceled with less than 24 hour's notice.** This fee is waived if you cancel or miss your appointment due to an emergency. This fee cannot be billed to your insurance and is your responsibility. A 1.5% service charge will be applied to any balance (not including pending insurance payments) after 30 days (18% APR).

At your request, my office will bill the appropriate insurance/managed care company (if applicable) for covered services you receive. The remaining balance, copay, deductible, or noncovered amount is your responsibility. Copayments are due at the time of your office visit. If you fail to obtain the required authorization from your insurance or managed care company, you will be responsible for the cost of your treatment.

If you do not choose to use insurance or if the services you receive are not covered by insurance, you will be responsible for paying for these services in full. Payment is expected at the time of your office visit.

If you do choose to use insurance, please be aware that certain clinical information must be disclosed before sessions can be authorized. This information typically includes (but is not limited to) your diagnosis, a description of the problem(s) for which you are seeking treatment, personal background information and medical history, and treatment goals.

By signing below you acknowledge that you have read and understood this document and that you agree to participate in psychological evaluation and/or treatment provided by Lisa D. Piechowski, Ph.D., that you have received a copy of the Notice of Privacy Practices, that you will be responsible for your account as outlined in the above paragraphs, that you authorize Dr. Piechowski to submit required information to your insurance or managed care company or to pay for the entire cost of these services at each session, and to allow Dr. Piechowski to contact your primary care physician and/or psychiatrist in order to coordinate treatment.

Signed: _____ Date: _____
Parent must sign if patient is under 18 years of age.

LISA D. PIECHOWSKI, PH.D.
Notice of Privacy Practices

This notice describes how protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I am dedicated to maintaining the privacy of your identifiable health information. In conducting my practice, I will create records regarding you and the services I provide to you. This Notice tells you about the ways in which I, Lisa D. Piechowski, Ph.D., may collect, use, and disclose your protected health information and your rights concerning your protected health information. "Protected health information" is information about you that can reasonably be used to serve you and that relates to you, or the payment for that care. I am required by law to maintain the confidentiality of health information that identifies you; as well as by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. I must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

If you have questions about this notice, please contact Lisa D. Piechowski, Ph.D. at 860-659-0732 for further information.

The terms of this notice apply to all records containing your health information that are created or retained by my practice. I reserve the right to revise or amend my notice of privacy practices. Any revision or amendment to this notice will be effective for all of your records my practice has created or maintained in the past, and for any of your records I may create or maintain in the future. I will post a copy of my current notice in this office in a prominent location, and you may request a copy of my most current notice by calling me.

HOW I MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

I may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures I may make without your authorization for payment and treatment.

Payment. I use and disclose your protected health information in order bill and collect payment for the services you may receive from me. For example, I may contact your health insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. I also may use and disclose your health information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, I may use your health information to bill you directly or services.

Treatment. I may use and disclose your protected health information to coordinate services with other health care providers involved in your care. For example, I may share diagnosis and treatment progress with a psychiatrist or another medical professional who is prescribing medications for you.

Release of information to Family / friends. I may release your health information to a friend or family member that is helping you to pay for your health care, or who assists in taking care of you.

Disclosures Required by Law. I will use and disclose your health information when I am required to do so by federal, state or local law.

Psychotherapy Notes. Psychotherapy notes will not be released without authorization except for my own use in treatment, for training purposes without disclosure of identity, or for purposes of defense if you bring legal action against me.

OTHER PERMITTED OR REQUIRED DISCLOSURES

As Required by Law. I must disclose protected health information about you when required to do so by law.

Public Health Activities. I may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury, or disability.

Victims of Abuse, Neglect, or Domestic Violence. I may disclose protected health information to government agencies about abuse, neglect, or domestic violence.

Health Oversight Activities. I may disclose protected health information to government oversight agencies. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Judicial and Administrative Proceedings. I may disclose protected health information in response to a court or administrative order. I may also disclose protected health information about you in certain cases in response to a subpoena, discovery request, or other lawful process.

Law Enforcement. I may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

To Avert a Serious Threat to Health or Safety. I may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Special Government Functions. I may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.

Workers Compensation. I may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have certain rights regarding protected health information that I maintain about you.

Right To Access Your Protected Health Information. You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include referral information, billing, claims payment, and medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. I may charge a fee for the costs of producing, copying, and mailing your requested information, but I will *tell* you the *cost* in advance.

Right To Amend Your Protected Health Information. If you feel that protected health information maintained by me is incorrect or incomplete, you may request that I amend the information. Your request must be made in writing and must include the reason you are seeking a change. I may deny your request if, for example, you ask me to amend information that was not created by me, or you ask to amend a record that is already accurate and complete. If I deny your request to amend, I will notify you in writing. You then have the right to submit to me a written statement of disagreement with my decision and I have the right to rebut that statement.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures I have made of your protected health information. The list will not include my disclosures related to your treatment, my payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, I may charge for providing the accounting, but I will tell you the cost in advance.

Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information. You have the right to request that I restrict or limit how I use or disclose your protected health information for services, payment, or health care operations. I *may not agree to your request*. If I do agree, I will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell me (1) what information you want to limit; (2) whether you want to limit how I use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

Right To Receive Confidential Communications. You have the right to request that I use a certain method to communicate with you or that I send information to a certain location. For example, you may ask that I contact you at work rather than at home. Your request to receive confidential communications must be made in writing. I will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have a right at any time to request a paper copy of this Notice. You may ask me to give you a copy of this notice at any time.

Contact Information for Exercising Your Rights. You may exercise any of the rights described above by contacting me.

Complaints. If you believe that your privacy rights have been violated, you may file a complaint with me and/or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.