Iadeluca NP Psychiatry PLLC

Iadeluca NP Psychiatry
7 Corporate Drive
Clifton Park, New York, US - 12065

Iadeluca NP Psychiatry New Patient Packet

Patient Full Name: *

Date of Birth: *

Treatment Authorization

Iadeluca NP Psychiatry, PLLC

I authorize mental health treatment of myself or my minor child by Kaitlynn Iadeluca PMHNP-BC at Iadeluca NP Psychiatry.
I understand that as a patient of Iadeluca NP Psychiatry, I (or my minor child) will receive care that will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me (or my minor child). Typically, treatment is provided on day of service and over the course of several weeks, months, years for chronic conditions. Your questions, concerns and possible or potential side effects of treatments will be discussed and disclosed to you. Every individual is different and responds differently to treatments therefore not all reactions are documented and can be predicted. It is your responsibility to keep us informed of any medication or physical changes and diagnosis, so we can coordinate it with your care and prevent any interactions with your treatment plan.

PATIENT/ PARENT OR GUARDIAN SIGNATURE *

Date *

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE IS NOT A RELEASE OF YOUR MEDICAL INFORMATION

This Notice describes how we may use and disclose your protected health information (PHI) 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. “PHI” 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. Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by your healthcare provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the provider's practice, and any other use required by law. TREATMENT: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home agency that provides care to you. For example, your PHI may be provided to a physician or healthcare provider to whom you have been referred to ensure that the physician or healthcare provider has the necessary information to diagnose or

treat you.

PAYMENT: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission. Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of your healthcare provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical or health profession students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your healthcare provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your PHI in the following situations without your authorizations. These situations include: Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates.Required uses and disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500. Other Permitted and Required Uses and Disclosures will be made only with your consent. Authorization or Opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your healthcare provider or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization. Your Rights: You have the right to inspect and copy your PHI, 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 PHI that is subject to law that prohibits access to PHI. You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI 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 healthcare provider is not required to agree to a restriction that you may request. If your healthcare provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. 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 alternatively i.e. electronically. You may have the right to have your healthcare provider amend your PHI, 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. You have the right to receive an accounting of certain disclosures we've made, if any of your PHI we reserve the right to change the terms of this notice and will

inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.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 contact of your complaint. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI.

Signature below is acknowledgement that I have received this notice of privacy practices.

PATIENT/PARENT OR GUARDIAN SIGNATURE *

Appointment Cancellation Policy

At Iadeluca NP Psychiatry we do understand that everyone has unplanned events that demand immediate attention and do require cancellation of appointments. However, we ask that you understand that your booked time is set aside especially for you. New evaluations usually last for approximately 60-75 minutes and follow-up visits usually last 20-30 minutes. When you cancel, these timeframes are visits that another patient could have received the care and treatment they needed. Therefore, if you must cancel with less than 24 hours notice, you will be charged $150.00 for your missed follow-up and $300.00 for your missed initial appointment. If you are more than 15 mins late for an appointment we reserve the right to reschedule your appointment for another time. Also, note, if you are late for your appointment, the amount of time for your appointment may not necessarily be extended. Since there may be other patients waiting, your appointment slot will remain the same.

PATIENT/PARENT OR GUARDIAN SIGNATURE *

Financial Policy

I authorize Iadeluca NP Psychiatry to charge my credit/debit card for appointments, sessions, cancellation fees, and/or other incurred fees related to services provided. Please be advised that payment for all services will be due at the time services are rendered. For your convenience we accept MasterCard, Visa, Discover, American Express, debit card, or check payments. If you are sent to collection, you are responsible for all collection costs, attorney's fees, and court costs.

If you have private insurance and choose to pay cash for services, we can provide you a Super Bill to present to your insurance carrier for reimbursement of fees. We advise you to check with your insurance company prior to your appointment to verify if they will accept a Super Bill for the fees that you have paid. We cannot offer any guarantee that your insurance carrier will reimburse you for these services. If you inquire after your appointment or if your insurance company does not accept Super Bills, then you will be fully responsible for all charges and fees incurred for the services received.

By signing below, I certify that I understand and agree to the financial policy presented to me by Iadeluca NP Psychiatry, PLLC.

PATIENT/PARENT OR GUARDIAN SIGNATURE *

By signing this form, I acknowledge that I have completely read this document in its entirety and understand the above disclaimers and agree to be bound thereby.

PATIENT/PARENT OR GUARDIAN SIGNATURE *

Date Signed *

Thank you for choosing Iadeluca NP Psychiatry, PLLC for your mental health care needs. We are honored to be of service to you and your family.