New Patient Packet

The enclosed forms must be completed, signed, and returned before a new patient evaluation appointment will be scheduled.

PATIENT INFORMATION SHEET
Provide contact information and insurance details

TELEHEALTH CONSENT FORM
We use HIPAA-protected Electronic Health System for secure video visits.

INFORMED CONSENT
Our commitment to you is respectful, timely care – specific to what YOU need – that keeps you close to home. Review our policies to know what to expect when working with us

PAYMENT POLICY
A card must be held on file for all copays, co-insurance, and late-cancellation fees.

INSURANCE CARD
Please provide a copy of both FRONT and BACK of your insurance card.

RELEASE OF INFORMATION
If you are treated by another therapist or provider and would like us to share information with them

If you would like HPA/LiveWell to share information with your parents/spouse/partner, complete a form to name that individual

PATIENT PORTAL
Set up your Patient Portal with activation code provided by phone or email

HAVE YOU COMPLETED THESE FORMS?

- ☐ Patient Information Sheet
- ☐ Telehealth Consent
- ☐ Informed Consent
- ☐ Payment Policy
- ☐ Insurance Card – front & back
- ☐ Release of Info (optional)
- ☐ Return ALL forms via Patient Portal Message
- ❖ ***PLEASE* provide best time to call you to obtain cc# by phone**

QUESTIONS?

New Patient Coordinator
PH: 518.218.1188 x1

PATIENT NAME (Legal)		
Preferred Name (optional)		
Date of Birth	Age	Gender
Address		
City	State	Zip Code
Cell Phone #		Cell Carrier
Patient Email		

PARENT NAME (IF PATIENT IS UNDER AGE 18)		
Relationship to Patient		
Address (if different)		
City	State	Zip Code
Parent Email		
Parent Cell #		Parent Cell Carrier
Special Communication Requests		

Emergency Contact Name
Emergency Contact #
Emergency Contact Relationship

Who referred you to HPA/LiveWell?
Reason for appointment/referral

INSURANCE INFORMATION

Primary Insurance Company		Policy # or ID #	Group #
Person Providing Insurance	Date of Birth - Person Providing Insurance	Relationship to Patient	
Secondary Insurance Company		Policy # or ID #	Group #

I authorize HPA/LiveWell to release any information acquired during treatment to my insurance carrier. This authorization shall remain valid until written notice is given revoking the authorization. I understand that I am financially responsible for all charges whether they are covered by insurance. This signature will authorize consent to treat the above-named patient.

PATIENT NAME:		DATE:	
PATIENT SIGNATURE:			
PARENT/GUARDIAN SIGNATURE: (if patient is under 18)			

CONSENT FOR PSYCHOTHERAPY VIA TELEHEALTH

I ___________________________________ hereby consent to participate in psychotherapy via telehealth with HPA/LiveWell.

I understand that "telehealth" is the practice of delivering clinical mental and behavioral healthcare services via tech-assisted media or other electronic means between a NYS licensed clinician and a patient who are located in two different locations. I understand that telehealth means using electronic information and communication methods to connect with providers to deliver assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient. I understand that by participating in telehealth, I will be sharing personal data, email messages, telephone conversations and interactive video and data communications with HPA/LiveWell.

PATIENT RIGHTS & RESPONSIBILITIES

1. I have the right to withdraw this consent at any time, without affecting my right to future care or treatment.
2. I acknowledge there are risks, benefits, and consequences associated with telehealth, including, but not limited to the transmission of personal information could be disrupted or distorted by technical failure, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I accept that HPA/LiveWell has implemented safety measures to ensure each telehealth session is secure and no part of an encounter will be recorded.
4. I understand telehealth sessions must maintain applicable privacy and security requirements, including but not limited to compliance with HIPAA. This means under no circumstance may anyone record any visual or auditory parts of telehealth sessions. **Breach of confidentiality relating to PHI (protected health information) violates NYS and Federal law.**
5. I understand that, although rare, tech problems may delay or interrupt a telehealth session. If a session is interrupted due to technology, all parties will attempt to log back in as soon as possible. If unable to connect within ten minutes, contact the HPA Admin Team via ***frontdesk@albanyhpa.com*** or **518.218.1188** to reschedule.

EMERGENCY PROTOCOLS

6. I accept that telehealth does not provide emergency services. If at any time I am at risk to harm myself or others, I agree that I will call 911 or proceed to the nearest hospital emergency room for immediate help.
7. I acknowledge emergency/crisis support resources are available from the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) or Albany County Mobile Crisis at 518.549.6500.
8. I agree to inform my clinician if I am participating in session from a physical location different from my address on file.
9. I accept that HPA/LiveWell requires an emergency contact person be identified for each patient to reach on your behalf in a life-threatening emergency. The emergency contact person will only be contacted to go to your location or take you to the hospital to help to keep you safe.

If I have any concerns related to my care, I am able and willing to contact either Dr. Julie Morison, HPA's Owner/Director, or Administrative Leadership via email at ***frontdesk@albanyhpa.com***.

By signing below, I have read and understand the information above, and all my questions have been answered to my satisfaction.

PATIENT NAME:		DATE:	
PATIENT SIGNATURE:			
PARENT/GUARDIAN NAME:		PARENT/GUARDIAN PH #:	
PARENT/GUARDIAN SIGNATURE:			
EMERGENCY CONTACT:		EMER. CONTACT PH #:	

INFORMED CONSENT FOR OUTPATIENT SERVICES

Welcome to HPA/LiveWell! This document contains information regarding the services provided by our clinical staff. Please read carefully and ask for clarification where needed. By signing this form, you acknowledge that you have read these policies and consent to participate in the treatment provided by HPA/LiveWell.

SERVICES PROVIDED

HPA/LiveWell provides a spectrum of psychological services including, but not limited to, individual and family counseling, ADHD testing and group therapy. Our intensive outpatient program (IOP) focuses on the treatment of eating disorders which includes nutritional counseling, group psychotherapy and medical follow-up for IOP compliance, as needed. We also offer outpatient services for psychological assessments as well as individual, family and group psychotherapy. Our clinical staff consists of doctoral degreed psychologists and doctoral trainees, a nurse practitioner, licensed dietitian, social workers and mental health counselors. HPA/LiveWell is a teaching practice that may have students present during select group and individual sessions. Please inform our administrative team if you wish to discuss the presence of students with our clinical staff.

Services vary depending on the personalities, orientation and education of therapists and patient, your goals for change and the areas you wish to address. Psychotherapy calls for a very active effort on your part and the most successful patients are those who utilize what they learn in treatment within their daily lives.

At times it can be helpful to have family members or a significant other participate in your care. If you feel this would be helpful, please work with your therapist to connect with these individuals.

Additionally, with your permission, and when appropriate, our clinicians would like to coordinate care with your other providers. Please make sure to notify your therapist of outside providers and complete the required Release of Information form(s) (ROI).

Please be advised that psychotherapy can have benefits and risks. Oftentimes, the information discussed may involve unpleasant aspects of your life and you may experience uncomfortable feelings. Changes made within your life can have a disruptive effect on your family and other interpersonal relationships, however psychotherapy has also been proven to have benefits to the lives of the people who go through it. Therapy often leads to solutions to specific problems, establishing healthy coping skills, improved relationships, and significant reductions in feelings of distress. There are no guarantees of what you will experience. Our intention is to provide a therapeutic environment which allows you to make the changes you seek.

CONFIDENTIALITY
Our minimum practice standards meet the standards of the Health Care Portability and Accounts Act (HIPAA).

COMMUNICATION WITH CLINICAL STAFF
The clinical staff are often with patients and, most times, not immediately available by phone. Along with our administrative team, HPA/LiveWell has confidential voicemail system that is regularly monitored, and calls are addressed in a timely manner. If your therapist is out of the office for an extended period of time, coverage will be prearranged and communicated to you. **Please be advised that we do *not* provide emergency or crisis care**. We advise you to contact your family practitioner, dial 911 or seek the nearest emergency center in the event of a life-threatening situation.

We are unable to ensure the confidentiality of any form of communication through electronic media and strongly advise you avoid these forms of communications. Should you wish to communicate with your clinician via email you must sign a release of electronic information form stating that you understand the risks associated with this form of communication. Contact our administrative team for more details. Communication with existing patients through the website is prohibited.

MINORS
HPA/LiveWell welcomes adolescent patients, however parental/ guardian consent to treatment is required. While parents/guardians have the legal right to all treatment information, it is our policy to ask parents/ guardians to respect the confidentiality of adolescents age 13 and over. Clinicians will provide parents/ guardians with general information about progress, either by phone or through family sessions, upon request. If a clinician believes there is imminent risk that an adolescent will seriously harm self or others, the clinician will disclose the information in accordance with ethical and legal obligations. Behavior that may negatively affect an adolescent patient's health or well-being will also be addressed with the patient's knowledge.

It is the responsibility of the parent/ guardian to inform the office of any custodial changes or of any limitations to the supports with whom contact is to be made.

APPOINTMENT POLICY
IOP services consist of four hours of treatment, four days per week. Outpatient services range from thirty minutes to an hour of scheduled treatment. Appointments are scheduled with the frequency determined by your therapist. We respect the time reserved for you and do not overbook appointments. **If you must cancel an appointment, you must contact our office during normal business office hours - with a minimum of 24 hours' notice - prior to your appointment. A $55 no-show fee will be applied if you fail to cancel your appointment with proper notice or do not show up for your appointment**. (Exception: you and your therapist agree that the circumstances did not permit advance notice.) After three "No-Shows" or late cancellations/appointment changes, your therapist will evaluate your privileges of scheduling future appointments. Please note that health insurance policies do not cover fees for missed/cancelled or "No-Show" appointments.

PAYMENT POLICY

Payment is expected at the time of service, unless another payment agreement is established. In circumstances of unusual financial hardship, a payment plan may be available to you.

It is your responsibility to ensure that your individual insurance policy covers mental health visits. You are responsible for paying all charges for services provided, regardless of payments from your insurance company. You are responsible for any and all visits or services not covered or partially covered by your insurance plan. This includes all payments, including co-pays, where appropriate. If payment is not made at the time of service, a $15.00 fee will be added.

For high deductible insurance plans, payment will be due when HPA/LiveWell receives notice from your insurance carrier that the visit was applied to your deductible.

Should your insurance policy lapse for any reason while receiving treatment at HPA/LiveWell, you will be responsible for all outstanding payments. Should any visits take place during a lapse in your policy, you will be billed at the full amount.

If you have an outstanding balance for services provided but not covered, you will not be able to make subsequent appointments until payment is made.

Please be advised there is a fee of $0.20 per page to copy your records. This fee is due when the records are received.

Our administrative team will be happy to answer any questions you have regarding this policy.

CONSENT FOR SERVICES

I, ____________________________, authorize HPA/LiveWell to provide services to the individual named below. I understand that the services may include a variety of those listed above and I am aware that participation in the named services is voluntary. I may limit or end services at any time.

I have read and understand the Informed Consent for Outpatient Services and by signing below agree to the policies listed within.

PATIENT NAME: ____
(Please Print)

PARENT/GUARDIAN NAME: ____
(If Applicable)

SIGNATURE: ____ DATE: ____________________

PAYMENT POLICY
January 2022 Update

HPA/LiveWell has implemented a new, convenient payment policy using credit card on file to streamline our billing and payment system to provide a secure way for patients to pay their bills. ***ALL Patients are now required to provide a credit card to be held on file to pay any charges that may be due.*** Before scheduling any future appointment(s), a credit card is now required to be stored securely in our system.

Cards on File will be used to pay your PATIENT RESPONSBILITY in the following way(s):

- **CoPays.** Your card on file will be used to collect your copay on the day of service.
- **Deductibles**. The card on file will be used to settle any deductible amount due after your insurance plan has paid their portion. [Reminder: Be sure to contact your insurance plan to determine how much of your annual deductible has been met prior to each visit.]
- **No Show Fees.** Per HPA/LiveWell Cancellation Policy, all patients are expected to cancel 24 hours in advance of a scheduled appointment to avoid a $55 late-cancellation fee. In the event of a late-cancellation/no show, your card will be charged $55.00. You will be unable to schedule a future appointment until that fee has been collected. Reminder: three late cancels/no-shows may result in discharge from this practice.
- **Outstanding Balance.** HPA/LiveWell has set a maximum charge of $250 each month. If you have a personal balance beyond that amount, you will receive subsequent charges until the full balance is paid. Call our billing department at 518.631.8380 to create a payment plan schedule to address any existing balance.

:: CONSENT REQUIRED ::
By signing below, I agree to the Credit Card on File Policy and I authorize HPA/LiveWell to:

- keep my signature and credit/debit card information securely on file in my account
- automatically charge my credit card for any personal balance due to patient responsibility
- charge my credit card $55.00 for any appointment that is not cancelled with 24-hour notice

I understand I am responsible for payment for all services HPA/LiveWell provides to me. I understand that my insurance may deny or delay payment for these services or only partially pay for them, and I agree I am financially responsible for any balance remaining. If the credit card I have on file changes, expires, or is denied for any reason, I agree to provide a new, valid card to HPA/LiveWell before any future appointments. I understand this consent may be withdrawn by me at any time. I understand that I may be denied treatment if I do not sign this consent form. I have received a copy of this form as recognized by my signature below.

PATIENT NAME:		**PATIENT ACCT #**	
CARDHOLDER NAME: (if different than patient)			
CARDHOLDER SIGNATURE:		**DATE:**	

Frequently Asked Questions (FAQs)

- **Must I provide credit card information to be a patient?** Yes. This is our financial policy for all patients. You've likely experienced this has become common practice among all healthcare providers. We have created this policy to be diligent and efficient in our billing and collecting processes. Alternative methods of payment may be used (ie: personal check, alternative card, CareCredit); however, a credit card on file is still required.
- **What if I cancel my appointment?** Per HPA/LiveWell Cancellation Policy, all patients are expected to cancel 24 hours in advance of a scheduled appointment to avoid a $55 late-cancellation fee. No show fees cannot be billed to insurance; all no-show fees are patient responsibility. The $55.00 charge is an administrative fee for failure to comply with HPA/LiveWell Cancellation Policy.
- **How much and when will cards be charged?** Your copay will be collected by credit card charge following your therapy service. If you have a high deductible plan, be advised it takes 2-3 weeks on average for insurance claims to be processed by your plan. Depending solely on your insurance policy, the amount you owe will be your copay, coinsurance, and/or deductible. Once our billing department has reviewed the insurance explanation of benefits (EOB) and posted it to your account, we will automatically charge your card for the balance due (up to $250 per month month) and issue a patient statement showing your personal balance (if any). If you have a large balance, it's important that you call our billing department at 518.631.8380 to discuss payment plan options.
- **How is card information stored?** We use the same methods to guard patient credit card information as we do for health information. The card information is securely protected by ***Global Payments***, the secure credit card component of our HIPAA and PCI compliant practice management system. This system stores the card information for future transactions using the same technology as online retailers. Our staff can't see the card number – only the last four numbers, giving us no way to use the card beyond the billing system, with no way to export the card information out of our system.
- **What if there is a payment discrepancy or I have other payment questions?** Please contact our billing department directly at 518.631.8380 to settle payment discrepancies or for other payment questions. This policy in no way compromises your ability to dispute a charge or appeal your insurance company's explanation of benefits.
- **How will I receive my patient statement?** Patient statements will continue to be issued monthly; available by USPS mail or online patient portal. At the close of the monthly billing cycle, any patient balance up to $250 will be automatically charged to the card on file and receipt will be sent to the email address on file. If a balance remains after that payment, a statement will be sent [online patient portal or US mail]. You may pay the statement balance by mailing a personal check or contacting our billing department at 518.631.8380 to charge your card on file.
- **What record will I have of an automatic payment transaction?** You will receive a receipt via email to the address you've provided in your patient record. The amount and date of the payment will show on your credit card/bank statement. Additionally, our Administrative Team will have a transaction report.
- **Why this policy change now?** In our ongoing effort to provide reliable, secure, and seamless encounters with our clinicians and staff, we've identified this as the most secure method of securing payment information to prevent interruption to services. No more writing checks, buying stamps, postal delays or handwritten credit card numbers on billing slips. Our Administrative Staff is available to help you set up your online payment portal by calling 518.218.1188, Option 2.

Authorization for Release of Mental Health Information via Electronic Transmission

This completed form authorizes the disclosure and/or use of personal health information about you.
Failure to complete all sections may invalidate this authorization.

Patient Last Name	Patient First Name	Patient Date of Birth
Patient Phone #	Patient Email	

I AUTHORIZE HPA/LiveWell TO DISCLOSE MY PERSONAL HEALTH INFORMATION TO:

Name of Provider/Person	Office/Affiliation	
Email	Phone	Fax

Relationship	Parent ☐	Partner/Spouse ☐	Primary Care ☐	Med Prescriber ☐	Dietitian ☐	Other (specify) ☐

I AUTHORIZE HPA/LiveWell TO RELEASE THE FOLLOWING INFORMATION:

Please release information of my care for this period:	From Start Date	To End Date
For the Purpose of:		
I request this Authorization to be valid and in effect until:	Termination Date	

Comments:

I request that HPA/LiveWell release health information regarding my care and treatment as identified on this form. I understand the risks of sending this information electronically. I understand I have the right to revoke this authorization at any time by contacting HPA/LiveWell in writing. All my questions about this form have been answered and I have retained a copy of this form for my records.

Signature of Patient/Guardian	Date Signed
Printed Name	If not patient, relationship to patient