CLIENT CONTACT INFORMATION SHEET

Stacey B. Shapiro, LCSW, LLC
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Birth Date: _____/_____/_____ Age:______
Gender:
Male
Female

Name:_________________________________
Address (Street and Number):_________________________________
City: _________________ State: __________________ Zip: _____________
Home Phone: (_____) _____-________

May We Leave a Message
Yes
No
Cell/Other Phone: (_____) _____-________

May We Leave a Message
Yes
No
E-mail:

May We Email You?
Yes
No

*Please note: Email correspondence is not considered to be a confidential medium of communication.
Occupation:

Place of Employment:_________________________________
Work Number: (_____) _____-________

If needed, is it OK to call here?
Yes
No

Emergency Contact:
Name:_________________________________ Relationship:_________________________________
Phone Number: (_____) _____-________

Notice of Privacy Practices
Stacey Baratz Shapiro, LCSW, LLC

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. I am required to make this information available to you because of the federal law, The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

My commitment to your privacy
I am dedicated to maintaining the privacy of your personal health information. The above law is complicated and in this letter I will cover some possible reasons for releasing your information. If you
have any further questions please do not hesitate to ask me questions inquiring further regarding this law.
I will use the information about your health, to provide you with treatment, to arrange payment for my services or for some other business activities, which are called, in the law, health care operations. After you have read this I will ask you to sign a Consent Form to let us use and share your information. If you
do not consent and sign this form, we cannot treat you or your child. If you or I want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an authorization to allow this. Of course we will keep your health information private but there
are some times when the laws require me to use or share is such as:

1) When there is a serious threat to your health and/or safety or the health and/or safety of another individual or the public. I will only share information with a person or organization that is able to help prevent or reduce the threat.
2) Some lawsuits and legal court proceedings
3) If a law enforcement official requires me to do so
4) For Worker's Compensation and similar benefit programs

Your rights regarding your health information
1) You can ask me to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask me to call you at home, and not at work to schedule or cancel an appointment. I will try my best to do as you ask.
2) You have the right to look at or receive the health information I have about you such as your medical or billing records. However, this does not include psychotherapy notes. If you wish for a copy of your record, you may be charged for copying costs.
3) If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and must tell me the reasons you want to make the changes.
4) You have the right to a copy of this notice.
5) You have the right to file a complaint if you believe your privacy rights have been violated.
You can file a complaint with me. All complaints must be in writing. Filing a complaint will not change
the healthcare I provide you in any way.
**The effective date is March 1, 2005

I, ________________________________, have read and understood the HIPAA guidelines that were given to me.

________________________________ ____________________

(Signature) (Date)

Stacey B. Shapiro, LCSW, LLC

I am now requesting that all clients have a current credit or debit card number (MasterCard, American Express or Visa) on file. This card will only be charged in the event that you have an outstanding balance on your account that is not met within 30 days of the statement date OR if you cancel less than 24 hours of your next appointment. If you would like your credit card to be charged for any given session it can be done upon your request.

Please let me know if you have any questions about this. Thank you.

Credit Card Information

Client name ____ (Please print)

Name on Card ____

Card Number ____

Three digit/four digit code ________________________________ on front/back of card

Expiration Date ____

I authorize Stacey B. Shapiro, LCSW, LLC to bill my credit or debit card in accordance with the terms stated above.

Signed ____

Date ____

• If you are a person who is paying for services for a patient, please sign below giving authorization to Stacey B. Shapiro, LCSW, LLC to bill the credit card or debit card in accordance with the terms stated above.

Signed ____

Date ____

Limits of Confidentiality

Psychotherapy is confidential, with the below stated exceptions.

Duty to Warn:
Therapists are mandated by law to disclose pertinent information discussed in therapy if the client has an intent or plan to harm another person. We are required to inform the intended victim and notify legal authorities.

Suicide/Self harm:
Depression is common emotion expressed in therapy, but if a client is feeling hopeless enough to imply or disclose a plan for suicide; steps need to be taken to ensure safety. This would include notifying the legal authorities as well as make reasonable attempts to notify the family. Animal abuse: I will report animal abuse, including cases of neglect and hoarding.

Vulnerable Adults and Children:
Mental health professionals are required by law to report stated or suspected abuse of a child or vulnerable adult to the appropriate social service agencies and/or legal authorities.

Prenatal Exposure to Controlled Substances: in keeping with protecting vulnerable populations, Mental Health Providers are required to report admitted use of controlled substances during pregnancy that are potentially harmful to the fetus.

Minors/Guardianship: Parents or legal guardians have the right to access a minor client's health information. Age of adult for psychotherapy is 14 .

Insurance Providers: Information requested includes description of impairments, dates and times of service, diagnosis, treatment plans, treatment progress, prognosis for improvement, case notes and summaries.

I have read and understand the above-stated limitations to confidentiality. I accept the subsequent ramifications should there be a need to act on one of the above stated exceptions. Other than the noted exceptions, if there are reasons to disclose my protected confidential information I understand that I will be provided a Release of Information form.

Client Signature: ____Date:___________